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The relationship between economic development and mental health : Nigeria, a case study.

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THE RELATIONSHIP BETWEEN ECONOMIC DEVELOPMENT AND MENTAL HEALTH: NIGERIA, A CASE STUDY

A Dissertation Presented

By

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DEDICATION

This study is dedicated to
My Father and Mother
Albert and Mary Whitehead.

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ABSTRACT

The Relationship between Economic Development and Mental Health: Nigeria, A Case Study

(September 1983)

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The purpose of the study, was to explore the relationship between mental health and economic development. The study assumed that economic development with concomitant westernization embraced an element of cultural change which affected the socio-cultural environment. Consequently the overall objective of the study was to explore potential causal factors inherent in the process of development that may generate negative consequences for mental health. The following four models of economic development were identified: Rostowian, Institutional-Structural, Dependency and Liberation models. Each model was assumed to have differential impact on mental health.

The study assumed that the sociocultural environment was the nexus of human adaptation and that change within the socio-cultural milieu had implications for mental health. Despite the importance

of mental health in the lives of people in the developing world, the study of its relationship to economic development was found to be much neglected in development studies.

To examine these factors an exploratory-descriptive design, using a case study of Nigeria was applied. The design was critical for the purpose of initiating the necessary task of theory building in this area of study. An extensive literature survey was conducted. The findings suggested that a development model heavily reliant on the diffusion of western values had financial and personal consequences for Third World people. Studies found that the clash between indigenous and western values had serious implications on how people perceived themselves.

The overall recommendations made were that:

(1) there be more integration of the African philosophy in economic development policy. In order to avoid severe psychological stresses associated with precipitous economic and cultural change;

(2) there be more dialogue between mental health and development specialists on the impact of development on human adaptation;

(3) education play a central role in integrating mental health concerns in overall economic development objectives;

(4) the educational programs be aimed at administrators and grassroots people.

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INTRODUCTION AND METHODOLOGY

Development Overview

This study focuses on the relationship between the course of economic development and changes in mental health conditions in developing nations. Four basic models of economic development are discussed in terms of their impact on mental health, defined as psychological well-being, in developing countries. Attempts are made to delineate features of economic development that have potential impacts on people living in traditional cultures and to specify areas of mental health most likely to show positive or negative effects of cultural and economic change. An analysis of Nigeria's mental health indicators is presented as an illustrated Case Study, through the presentation of its pattern of economic development and the relationship of this course of development to mental health.

The issue of development in the Third World has received widespread attention since World War II.[1/] The question has been, how to minimize the growing problems of underdevelopment. This dialogue, conducted at both international and national levels, has concentrated on the objectives and means of enhancing the

quality of life in Third World countries through the development of their economic and cultural institutions. This discourse was officially formalized at the international level through the declaration of the first development decade (1960-1970)[2/] by the United Nations (UN).

At no other time in history of this debate have the discussions of strategies of economic development been as formidable as they are today. The 1981 Cancun North-South Summit was a good example. The meeting provided the developing and developed countries with an opportunity to present their perspectives on economic development. These discussions of appropriate courses of action have proved to be inconclusive, resulting in a continued lack of consensus on a plan of action. The only matter upon which the participants were able to agree was their mutual commitment to development. The stance taken by the developed countries was in keeping with the predications of the Brandt Report.[3/]

In this report developed countries were predicted to be reluctant to express their commitment to development in material terms, e.g. through the infusion of more aid to developing countries, since the developed northern countries were experiencing serious economic problems of their own. In contrast, developing countries requested more aid and more parity in international trade. Member countries of the Third World argued that their lack of development and continued economic stagnation could pull the world economy into deeper trouble.

This argument, presented by Third World countries, was advanced by the International Monetary Fund (IMF) and its supporters as they sought increased contributions from member countries to "bail out" developing countries which otherwise might have to default on their loans (Washington Post, 1983). The IMF argued that default on loans by developing countries would create an economic crisis by drawing the world economy into further recession. These contrasting perspectives on the issue of development have raised tensions in international relations and prompted Wionczqek (1981) to conclude that the contemporary era of development was characterized by deteriorating relations between north and south. Thus, what has come to be known as, the third development decade has begun with less optimism than the previous two (Gvishiani, 1980; Young, 1982).

Development in Africa

The dialogue on development in Africa is particularly intense because of massive underdevelopment in this region. Africa is by far the most underdeveloped area of the Third World and one most in need of services because of its extensive problems (Arnold, 1980; Crocker, 1983; First, 1981; Morris, 1979; and Young, 1982). Arnold summarized this reality as follows:

> Africa is by far the most underdeveloped of the Third World continents. Africa in 1976, with 7.5 percent of the world's population accounted for only 1.2 percent of

> the global GNP. Latin America with only a slightly higher population (7.6 per cent) accounted for 4.8 percent of the world's GNP. The average per capita GNP was $277 for Africa, $315 for Asia and $1,050 for Latin America (Arnold, 1980: 295).

Young (1982) endorsed the above observation in a more qualitative manner. He concluded that the contemporary lack of enthusiasm with which African development was approached was largely due to the chronic nature of underdevelopment in Africa. This lack of enthusiasm was a far cry from the early sixties, when African scholars and politicians as well as their western counterparts approached the question of African development with an excitement born out of the hope of independence.

Within the debate on African development there were contrasts between the African and Western perspectives on the direction development should take. These contrasting perspectives were similar to those expressed at the Cancun North-South Summit of 1981. One of the central features accountable for these differences was the reality that the African perspective on underdevelopment was colored by what politicians and scholars perceived as the economic and social legacies of colonialism. The western perspective tended to place less emphasis on colonialism as a contributing factor to current underdevelopment (Crocker, 1983). Nevertheless, despite these differing viewpoints, Crocker (1983) was of the opinion that there was more uniformity than popularly believed between the African and Western perspective on the overall needs of the continent.

These lingering unresolved issues of colonialism within the African discourse on economic development required that a distinction be made between economic development with westernization and economic development without westernization. In the former case, development was conducted upon the premise that institutional development, necessary for economic development, can only occur when institutions operated from a western value base. The latter form of development ensued through the blending of western and indigenous value systems. This was an important differentiation in this study because development in and of itself is good and inevitable.

Development and Mental Health

Despite contrasting perceptives regarding the overall debate on development, the past two development decades (1960-1970; 1970-1980) have witnessed much action through the deployment of ambitious educational, health and social programs in developing countries. These programs were preceded by extensive research documenting their needs in the development process. As a result of this research, literacy, basic health, and manpower development were considered important social indicators of development especially during the second development decade (1970-1980).

The eclectic intellectual constituency studying development patterns has produced an abundance of research in the fields of:

Sociology-Inkeles and Smith, 1974; Education-Ahmed and Coombs, 1977; Freire, 1974; and Political Science-Goulet, 1971. A distinctive feature of these studies was their marked exclusion of mental health considerations, despite the crucial role played by mental health in the lives of the people toward whom these studies were directed. This has been largely due to the traditional dominance of economists in development research. As a discipline, orthodox economics eschewed non-economic factors, including mental health. As a result of this influence, development research became more concerned with raising production than evaluating human adaption in response to economic development. This produced a situation which led to the focus of development on countries rather than people (Streeten, 1972).

With the exception of some pronouncements made by the World Health(WHO) on the importance of mental health in overall economic development, there were very few studies that concentrated on the positive or negative changes that could occur within the socio-cultural environment as a result of economic development. WHO described the implications of change contained in economic development as follows:

> The process of development itself produces problems of adjustment and adaptation that should be of general social concern, as well as having important implications for mental health (WHO, 1975: 10).

The above statement by WHO described the major research question in this study: the relationship between mental health and

economic development. This investigation was conducted within the context of the process of economic development that is accompanied by westernization, the assumption being that economic development of this nature tends to cause erosion in the social fabric of indigenous cultures thereby creating problems of adaption.

As a field of study, mental health concentrates most specifically on human adaptation. It provides the professional with the necessary framework for analyzing the nature of these adjustments, whether they be negative or positive. It can, therefore, make those involved in development work more sensitive to the human factor in the process of economic development.

Mental health in Africa

Nowhere was the exclusion of mental health issues as significant as in the African Continent (Diop, 1973; German, 1974). For some African mental health specialists such as Neki (1975), this was a blessing in disguise because it allowed Africans to develop an indigenous mental health system, a system based on the African holistic philosophy. However, a system based on such traditional values has not yet emerged.

Mental health services on the African Continent remain custodial in nature, using facilities inherited from colonial times (German, 1971; Youssef, et al, 1974). This institutional framework for mental health services was considered inadequate to provide

even those curative services for which it was ill equipped. The shortage of conventional services accompanied by growing incidences of classical mental disorders prompted German (1971), to warn that unless the situation was corrected a crisis was inevitable. Ihsan (1982) supported this statement in his observation that developing countries were experiencing an increase in mental illness.

In referring to the classical syndromes of mental disorders German (1971) was applying a western perspective of mental health. In Africa this point of view dominated the formally organized system of mental health servicing the mentally ill. It emphasized the identification of cases which could be diagnosed in keeping with the universal psychiatric nomenclature. Patients who approached this system of mental health were often those who had failed to find a cure in the undocumented traditional system of mental health which functions parallel to the Western System (Draguns, 1982). Consequently the formal system represented the universal concepts of mental health while the formally unstructured system represented the more cosmic African perspective of mental health.

Mental health in the African tradition refers to a condition in which individuals are able to meet their commitment to themselves, others and the community. These three areas of functioning are in constant interaction with each other, affecting individual adjustment. Based on African philosophy, which emphasized values

of affiliation and communal living, the point of focus was the impact of value change on human adjustment.

In light of the chronic nature of African underdevelopment and the state of mental health in Africa, the study addressed itself more specifically to the cumulative impact of underdevelopment on mental health.

Mental health in Nigeria

Nigeria is probably one of the few countries on the African Continent which has produced extensive research materials on the question of mental health. Most of the mental health related studies done in Africa such as Amer (1970), Inkeles and Smith (1974) and Leighton et al (1963) were based in Nigeria. Nigerian mental health specialists, such as Lambo (1960) have produced critical writings on the subject of mental health in Africa and Nigeria.

Despite these sources of indigenous research, Nigeria is representative of the independent countries of sub-Saharan Africa in its lack of a clearly articulated mental health policy integrated in overall development strategy. Furthermore, the country's pragmatic policy of economic development, which has distinctive features of capital accumulation, made it even more representative of the many independent African countries who have adopted a similar model of economic development. In addition to these factors,

Nigeria is endowed with abundant natural and human resources which have made it prominent in international and African affairs. This natural endowment prompted Shaw and Grieve (1977, 1978) to term Nigeria "the giant of Africa". It in light of all these factors that Nigeria was selected for the purposes of a case study illustration.

Purpose of the Study

The major objective of this study will be to examine the relationship between mental health and economic development using Nigeria as a case study. In determining this relationship, the study will also examine factors of economic development which may have negative or positive impact on the mental health of people in developing countries. The overall assumption in this study was that economic development, because it embraces an element of social change (Goulet, 1971), has both negative and positive consequences for human adaptation. The positive consequences may be improved educational and health facilities, while the negative consequences may be embodied within behavioral responses which may be deemed inappropriate by indigenous cultures. Negative behavioral responses may manifest themselves through conspicuous mental illness or through social problems, such as alcoholism or increase in juvenile delinquency.

In conducting the overall analysis and examination of the relationship between economic development and mental health, the following research questions will be addressed:

1. What is the philosophy, policy and mode of program implementation regarding mental health in Nigeria?

2. What do Nigerian scholars say about mental health in the context of economic development?

3. What is the philosophy and policy of economic development in Nigeria?

4. What do development specialists, including Nigerian development specialists, say about economic development?

5. What processes of change in value systems or belief orientation set in motion by economic development have an impact on mental health?

6. What should be the role of education in the integration of mental health in overall development?

7. What are the distribution patterns for Nigeria for the selected period of study? How was the GNP spent?

8. What are the implications of these spending patterns on mental health?

9. What are the implications of the study on overall development planning?

Research Design

This study was an exploratory-descriptive one based on extensive library research as well as interviews with Nigerian officials in the United States, United States public health officials, World Health Organization officials, World Bank officials, and correspondence with mental health specialists in Nigeria.

The library research was conducted at the following libraries:

1. University of Massachusetts
2. Smith College
3. Harvard School of Public Health
4. Boston University African Studies Library
5. World Health Organization, Latin American Regional Office, Washington, D.C.
6. African Bibliographic Center, Washington, D.C.
7. Nigerian Mission, New York City
8. World Bank and International Monetary Fund joint library, Washington, D.C.
9. Johns Hopkins School for Advanced International Studies, Washington, D.C.
10. George Washington University Libraries, Washington, D.C.

The study was defined as an exploratory-descriptive one because the field of inquiry had limited theoretical development, that is, mental health and economic development as related issues have not been extensively investigated.

A detailed description of the nature and use of an exploratory-descriptive study was contained in the works of Forcese and Richer (1973) and Polansky (1960). This design, has historically been applied when the area of study had a limited conceptual base (Fineston and Khan, 1960; and Forcese and Richer, 1973). Consequently, it became a critical mode of investigation in research where the primary objective was to formulate a knowledge base. It may take the format of a case study or survey. The case study format allows

a more in-depth analysis of the selected entity, by exploring it along several levels.

This design was considered appropriate for this study because:

1. The variables, under exploration mental health and economic development, have not been sufficiently investigated to form a meaningful knowledge base.

2. It allowed the use of existing administrative statistics in the overall analysis, without the study being defined as experimental.

3. The beginning of a conceptual base could be built around the issues of mental health and economic development.

4. Most importantly, these variables could be studied through the extensive examination of literature.

A major part of the study was based on a literature survey which will be presented in Chapters II and III. A theoretical framework was drawn from the literature research which then formed the tool of analysis for a discussion on the Nigerian case study.

To augment the literature with studied observations, interviews were conducted at the policy level. At this level interviews were conducted with officials at the World Health Organization, Nigerian mission personnel, United States public health officials, and World Bank officials who are all involved to varying degrees in influencing and formulating the economic and health policies of Nigeria. The major objective in conducting these interviews was to establish:

1. whether Nigeria had an active mental health policy as part of development;

2. what future plans, if any, did Nigeria have regarding mental health;

3. what the officials saw as the status of mental health in overall development work.

The interviews were semi-structured, allowing respondents to explore related areas of concern.

Data Analysis

The overall objective in gathering the information in the study was to present a descriptive analysis of its implications for mental health. There will be two levels of data analysis, the qualitative and quantitative form. The qualitative analysis will embrace the African philosophies while the quantitative form of analysis will represent the highly documented western philosophies of health and development. As an African, the researcher will draw heavily from the African perspective in order to evaluate the impact of economic development on mental health.

More specifically the qualitative mode of analysis will embrace research questions 1 to 6 of this study while the quantitative approach will be applied to questions 7 and 8. Question 9 will be contained in most of the discussions throughout the study. Questions 7 and 8 will be further delineated by a presentation of the following administrative statistics:

1. Gross National Product recordings for the selected study period, 1972-1977.

2. Distribution patterns created by federal investment practices for the same period.

3. Frequency distribution patterns of psychiatric admissions for the study period.

Review of the Literature

The literature review was conducted at the general and specific levels:

1. The first level of the literature review contained in Chapters II and III is a more general one. It is aimed at exploring what other scholars have to say about economic development and mental health. Chapter II will present an overview of the selected development models; Chapter III will give an overview of pertinent mental health concepts.

2. At the specific level, literature pertinent to Nigeria will be presented in Chapter V. The literature will be in the form of a review of the second (1970-1974) and third (1975-1980) development plans which are primary sources of information. A second and very important body of literature will be the review and discussions of these plans by a variety of specialists. It is at this level of inquiry that Nigerian development policy as well as mental health philosophy and policy can be gleaned.

Development studies and mental health studies as separate areas of inquiry are distinguished by a wealth of information. The main objective of the study will be to examine literature that attempts to relate these two areas more closely. This implies that some of the literature that discusses development in pure econometric terms will not be considered. Such material will be considered only when it illlustrates how such a pure approach affects people. Similarly, a classical approach to mental health will be avoided because it does not take into consideration sociocultural factors considered important in this study.

It cannot be sufficiently emphasized that although the study draws for its analysis from the stress-related theories it does not deny the genetic approach to personality development. The overall approach is that while each person is born with a unique disposition the full maturation of individual personality is affected by the sociocultural environment within which he/she functions. By selecting economic development as a major variable in the study the focus is the sociocultural factor a bias that might lead the reader to assume that genetic factors are disregarded.

Important resources in the literature are: Weinberg, Abraham A. Migration and Belonging: A Study of Mental Health and Personal Adjustment in Israel (1961); and Leighton, et al, Psychiatric Disorder Among the Yoruba: A Report from Cornell-Aro Mental Health Research Project in the Western Region of Nigeria (1963). The Leighton et al study is particularly pertinent as it was based in the geographic area of the study. Nevertheless, the Weinberg (1961) study provided an important conceptual base. Reports and study group findings provided by the World Health Organization were particularly relevant for this study because WHO has important influence on health programs in the developing countries.

The literature reviewed in presenting the selected models of development was examined with a view to giving only the guiding principles of each model. An in-depth analysis of each model was beyond the scope of this study as it would have been more appropriate in a treatise on economic theory. The essential ingredient

in the overall analysis was the delineation of basic assumptions supporting each model in order to clarify the overall development policy embraced. Another distinguishing feature of development literature reviewed for this study was that it dated back to Rostow's theory of economic growth, which was formulated in the early sixties. The significance of this historical demarcation lies in the reality that development theory in relationship to the Third World can be said to date back to this period. There was a new sense of urgency about the development or lack of development in Third World countries, which was expressed in the declaration of the first development decade (1960-1970) by the United Nations (UN).

Limitations and Delimitations of the Study

This study will be limited to the investigation of mental health in its relationship to economic development. Community mental health status in Nigeria will not be dealt with because to ascertain this would require extensive field surveys with access to the clientele.

The limitations of this study were contained in its design. It was not an empirical study and, therefore, generalizations that could be drawn could only be limited. The field of inquiry was extremely limited so that a strong hypothesis for field testing would be difficult to describe. The use of western formulated

nomenclature was an important limitation because it was culturally biased and very often did not embrace the sociocultural dimensions and philosophies of Africans.

Significance of the Study

This study has significance ranging from the specific level for Nigeria to the broader level for other developing countries.

1. At the specific level, it can be said that because it was focussed on Nigerian development through a close scrutiny of specific development plans--second (1970-1972) and third (1975-1980)--it could contribute to a more specific policy for mental health that would enhance a comprehensive approach to development for Nigeria.

2. For Africa as a region, the study would sensitize planners to the impact of development on human adjustment. Since development patterns are more similar than disimilar among these countries, perhaps their development policies will be affected so as to include mental health considerations.

3. It will contribute to development literature.

Definition of Terms

Economic Development

Todaro's definition of economic development is one acceptable for this Study. He defines economic development as:

> A multidimensional process involving the reorientation of entire economic and social systems. In addition to improvements in incomes and output, it typically involves

> radical changes in institutional, social and administrative structures as well as in popular attitudes and, in many cases, even customs and beliefs (Todaro, 1981: 56).

This definition does highlight the positive and negative outcomes of structured development and, more importantly, alerts the reader to possible impact on human adjustment. In this study, the terms economic development, national development and development will be accepted as meaning the same and will be used interchangeably throughout the study.

Economic Growth

In this study economic growth will be taken to mean a condition where objective development is equated with an increment in the Gross National Product (GNP) (Little, 1982; Henriot, 1979).

Sociocultural Environments

Sociocultural environments in this study will be accepted as meaning those structured interactional patterns of behavior governed by a core of indigenous norms and values guiding appropriate behavior in specific social context (Weinberg, 1961; Leighton et al, 1963).

Mental Health

In this study mental health will refer to the individual's ability to function within a specific sociocultural environment reflected through his/her ability to maintain positive relationship with fellow members of the society. Such functioning must persist even under introduced changes in institutions (WHO, 1959, 1975; Lambo, 1960; Maslow, 1968).

Mental Disorders

Mental disorders will be defined as extreme manifestations of inappropriate behavior. This implies that the form of behavioral adaptation acquired by individuals results in their inability to perform the tasks normally expected of them in their social ranking. Furthermore, they can no longer meet the emotional needs of those dependent on them. In this study, mental disorders and mental illness will be used interchangeably.

Mental Health Services

Mental health services will mean the formal structures, visible to the naked eye, such as physical plants, professional personnel which are specifically set aside for caring for the mentally ill (Navarro, 1976).

Mental Health Resources

In this Study mental health resources will include other sources than those mentioned under mental health services above, which can be channelled towards the care of the mentally ill. Mental health resources, will embrace the African traditional system of healing, meaning traditional healers and their vast repertoire of techniques including their pharmacopoeia. It will further include educationists, community leaders and public health workers.

Developing Countries

Developing countries will mean those countries of Asia, Africa and Latin America considered to be suffering a great deal of poverty, poor health and representing collectively the highest concentration of mankind (Wilbur, 1979; Brandt Report, 1980). The same meaning will be applied to developing nations, less developed countries (LDCs) and Third World countries. These terms will be used interchangeably.

Developed Countries

Developed countries will be a term used to denote those countries with a high level of industrialization accompanied by low

mortality rate. Included in this definition will be the countries of North America, East and Western Europe, and the Soviet Union (Brandt, 1980; Wilbur, 1979) even though, like the developing countries, the developed world is not homogeneous.

North and South Dialogue

North and South Dialogue will refer to those forms of communications between the developed and developing countries specifically geared toward development strategies including parity in trade agreements.

Policy

Policy will be taken to mean a clearly delineated course of action spelling out steps which a country proposes to follow to acquire economic development or any objective it sets out for itself (Young, 1982).

Underdevelopment

Underdevelopment will be defined in this study as a situation in which the decision-making mechanisms on economic and therefore socio-political factors of a poor country are influenced by wealthier countries because of the latter's control of the growth sector.

Formal Education

Formal education will mean structured curricula which prepare pupils or students to function effectively in a modern economy (Amer, 1970; Crane, 1965; Holsinger and Theisen, 1977).

Model

A model will be defined as an abstraction of social and economic realities bound in a philosophical or theoretical formulation which represent a design by a careful delineation of plans for action. Paradigms and typology will be used interchangeably with model in this study as they are accepted as projecting the same meaning.

Westernization

Westernization will refer to a process whereby economic development is accompanied by the indiscriminate absorption of western values.

Organization of the Study

The study is organized in six chapters. Chapter I outlines the purpose, significance and design of the study.

Chapter II presents an overview of the four selected models of development, Rostow's model, the Institutional-Structural model, the Dependency model and the model of Liberation. Basic assumptions embodied under each model are briefly presented as well as the critique.

Chapter III describes significant western mental health paradigms followed by discussions of their applicability to third world people by third world mental health specialists. The concepts of traditional healing are presented briefly. The second section of this chapter gives a theoretical overview of schizophrenia and personality disorders as two diagnostic categories utilized in the study.

Chapter IV is a point of synthesis where development theory and mental health theory, discussed in Chapter II and III respectively, converge and form a conceptual framework for the study.

Chapter V forms the case study in which the development and mental health policies, philosophies, and implementation methods of Nigeria are described.

Chapter VI is the conclusion which outlines findings and presents recommendations.

Footnotes -- Chapter I

1 Chester Crocker, "Our development dialogue with Africa," Mimeograph . March 3, 1983.

2 Willy Brandt. North-South: A program for Survival. Cambridge: M.I.T. Press, 1980.

3 Ibid.

C H A P T E R II

DEVELOPMENT MODELS: AN OVERVIEW OF SELECTED THEORIES

Introduction

In order to establish critical linkages between mental health problems and the process of economic development in the Third World it was important to first consider properties of various models of economic development often adopted in these countries. An analysis of these models provided differential prediction regarding their consequences for mental health impact in developing countries. The major focus in this chapter will be to present an overview of four models of economic development: (1) Rostow's stages of growth; (2) the Institutional-Structural school of thought; (3) the Dependency model and (4) the Liberation model of development.

Theories embodied in these models have played an important role in the economic planning of Third World countries. For example, at the domestic level Nigeria adheres to Rostow's principles of economic growth, while supporting the dependency model of economic development in international affairs. The former model promotes economic growth through capital accumulation while the

latter model calls for equity in world trade. The conceptual bases of these models are critical for a fuller understanding of social policies outlined by the developing world.

Identifying Selected Models of Development

Overview

Streeten (1972), an economist, was of the opinion that economic theory was distinguished by the abundance of theoretical constructs aimed at explaining and proposing solutions for the problems of developing countries. In reviewing the use of these constructs in development planning, he was extremely sensitive to their usefulness and relevance to developing countries. Relevance and usefulness were matched through a careful examination of the underlying assumptions--to ensure that these were realistic for developing countries (Streeten, 1972). For this study the author was cognizant of these evaluations and selected four models which have significantly influenced discussions and approaches to economic development in the Third World for the past two decades (1960-1970; 1970-1980). These models are:

1. stages of growth;
2. institutional-structural school of thought;
3. dependency model;
4. liberation model of development.

The first model differed most significantly from the remaining three constructs which appeared to share assumptions.

Development models have historically played an important role in influencing the course of economic development. Although they are theoretical constructs describing economic and social realities, the assumptions upon which they were built often governed development planning (Streeten, 1972). Planners faced with the problems of development often perceived these propositions as offering alternative means to economic prosperity. Therefore, development models have often been the foundation upon which national hopes and aspirations for development were based. For example, the United Nations first development decade (1960-1970) was heavily influenced by Rostow's model of economic development as elaborated in his book entitled: The Stages of Economic Growth (Henriot, 1979). Rostow equated development with an increase in the Gross National Product (GNP). Because of the significance of these models to economic development, the overall task in this chapter will be to:

1. identify the models;
2. describe the basic assumption upon which they are based; and
3. present brief critiques on their relevance to developing countries.

Rostow's Development Model

Characteristics. This model of development was an important

one to consider because its assumptions were "deeply embedded in current thought on development" (Streeten, 1972: 5). As mentioned earlier in the introductory paragraph of this chapter, it played a critical role during the United Nations first development decade (1960-1970) by influencing its approach to development (Henriot, 1979). Development was equated with "a 5 percent annual increase of GNP in the developing countries" (Henriot 1979: 7) postulated by Rostow. Very often this model was referred to as Rostow's model of economic development by people such as Navarro (1976) or as a diffusionist model of development by Chilcote and Edelstein (1974). These terms will be used interchangeably in this study.

The overall assumption of this model was presented by Streeten as the:

> View that each country passes, at different times, through a series of comparable stages of development; that there are basic similarities in this process; and that we can therefore learn from the pre-industrial phase of now industrialized societies lessons which are applicable to underdeveloped societies today (Streeten, 1972: 5).

The characteristics of these stages referred to by Streeten were described in the writings of development analysts such as Henriot (1979); Chilcote and Edelstein (1974); Navarro (1976); and Rostow (1973). They all described the five stages of economic growth as:

1. traditional society;
2. the preconditions for take-off;
3. the take-off;

4. the drive to maturity;

5. age of high mass-consumption.

The traditional society. During this phase the society was predominantly agrarian in nature. Agricultural production was aimed at subsistence rather than surplus production for export. Production was labor intensive rather than mechanized (Chilcote and Edelstein, 1974; Todare, 1981). According to Griffin (1979), most protagonists of this model perceived most developing countries to be at this phase of economic development.

The preconditions for take-off. Navarro (1976) considered this phase as critical to this model. It was a transitional phase during which the traditional way of doing things gave way to new methods considered more effective. Subsistence farming slowly gave way to large-scale agricultural production for export. The changes that occurred during this phase were externally induced, for this phase arose, according to Rostow "not indigenously but from external intrusion by more advanced societies" (Navarro, 1976: 6). A conscious decision was made to develop "a 'leading sector' in the economy which positively influences other sectors" (Henriot, 1979: 7).

The take-off. This stage was described by Rostow as the "great watershed in the life of modern societies" (Navarro, 1976:

6). Resistance to growth was overcome, and dramatic changes in agricultural production took place. Production became capital intensive with the introduction of technology. Concomitantly, agricultural activities became less important and industrialization assumed high priority. Urbanism became the norm through the concentration of industrial activities in urban centers (Griffin, 1979; Henriot, 1979; Navarro, 1976). This phase could be attained through substantial increments in GNP. Such increments in the GNP should, according to Rosow (1973), allow for a savings of at least 5%-10% of the national income.

This overall premise of capital accumulation and savings as a means to economic development helped the United Nations in presenting its formula for economic prosperity in the first development decade (1960-1970). The UN's recommendation was that developed countries infuse capital into developing economies through liberal bank loans and massive foreign aid (Henriot, 1979).

The drive to maturity. Growth experienced in the third phase was enhanced and solidified through continued savings and investment. This phase was considered to be extremely vulnerable to social processes such as political instability which could retard growth or create economic regression (Henriot, 1979).

Age of high mass-consumption. Rapid economic changes experienced in the second, third and, to some extent, in the fourth

stage ceased. Consolidation of growth experienced in the previous phases occurred. Institutions became constant and demand for consumer goods increased (Henriot, 1979; Navarro, 1976; Illich, 1979). It was in this respect an idealized phase and one towards which most developing countries aspired. Developed countries are considered to have achieved this stage.

This approach to development was introduced to development circles in the sixties and has been part of the discourse on development since (Griffin, 1979; Streeten, 1972). According to Rostow (1973), this entire development process took approximately two to three decades. Progression through these stages could occur only through the diffusion of capital from the developed to the developing world (Navarro, 1976). The conviction with which supporters of this model believed its principles was reinforced by the success of the "Marshall Plan" devised by the United States to rehabilitate Europe. Devastated by World War II, Europe was badly in need of reconstruction. The Marshall Plan, which consisted of American capital infused into Western Europe, helped in its speedy recovery (Griffin, 1979; Todaro, 1981). This quick rehabilitation of Europe prompted the developed countries to apply the same treatment to developing countries. These measures were applied because of the following assumptions:

1. Economic growth represented by a quantum leap in Gross National Product was equated with development (Streeten, 1972; Henriot, 1979; Griffin, 1979).

2. Economic growth automatically trickled down to the poor (Streeten, 1972; Hicks and Streeten, 1979).

3. Diffusion of capital from the developed countries to the industrialized sectors--mainly urban areas --of developing countries would stimulate development in these sectors and would in turn generate the infusion of capital and entrepreneurial values to other areas--mainly rural areas--resulting in the development of entire countries (Navarro, 1976).

4. Illiteracy, stagnant economies, and poverty were perceived as the leading causes of underdevelopment (Chilcote and Edelstein, 1974).

Criticism of the model. The criticism leveled at this model has been directed at its inherent weaknesses. The most articulate critics of this model were: Chilcote and Edelstein, 1974; Griffin, 1979; Hicks and Streeten, 1979; Navarro, 1976; Rodney, 1974; Streeten, 1972; and Wilber and Weaver, 1979, to name just a few.

According to their arguments Rostow's basic assumption, that a numerical increase in GNP trickled down to the poor, was considered invalid (Hicks and Streeten, 1979; Wilber and Weaver, 1979). Wilber and Weaver (1979) negated this assumption by quoting extensive research by Adelman and Morris which conclusively established that:

> As economic growth begins in very poor countries, the share of income going to the richest 5 percent of the population shows a "striking" increase, while the income going to the bottom 60 percent of the population falls relatively (which was already known) and, in certain cases, absolutely, as well. That is, the bottom 60 percent of the population have less to live on after growth begins than they had before (Wilber and Weaver, 1979: 115).

The percentage breakdown in this statement implied that the middle income bracket of thirty-five percent was a minority in developing countries. Furthermore, the suggestion was that economic growth can contain growing disparities brought about by unequal distribution of national wealth. The inability of this model to explain these contradictions caused disillusionment and overall invalidation of its trickle down theory (Henriot, 1979; Wilber and Weaver, 1979);

Dependency theorists such as Baran, 1979; Dos Santos, 1970; Frank, 1972, 1979; and Navarro, 1976, were particularly critical of this model. Their major differences with this model could be summarized as follows:

1. Underdevelopment according to these analysts was a function of too much diffusion of western values to developing countries and not of too little diffusion.

2. Centralized development in the cities and urban areas contributed to the underdevelopment of rural areas through neglect.

3. Concentration of development benefits such as improved health facilities, educational institutions of higher learning and employment opportunities in the cities tended to encourage rural to urban migration.

4. Placing contemporary developing countries in the first stage of growth--the traditional stage--was, according to these analysts, unacceptable. It implied that developing countries today reflect the same characteristics manifested by European institutions before the industrial revolution. This also overlooked a discussion of economic and social institutions as they existed in precolonial times, a step that denied developing countries their socio-political history.

In keeping with the first point of criticism above, the major issue for these critics was in the overall definition of underdevelopment which they perceived as a function of unfair international economic relation. The balance tipped too much in favor of the developed countries. Illiteracy, poverty and unemployment were symptoms, not causes of underdevelopment.

Structural-Institutional Model

Characteristics of the Model. This paradigm has an eclectic intellectual constituency made up of proponents from different ideologies, disciplines and backgrounds, educationists--Freire, 1974; Ahmed and Coombs, 1974; economists--Streeten, 1972, 1981; Seers, 1969; politicians--Nyerere, 1967, 1977; Cabral, 1973; political scientists--Goulet, 1971, 1980; and philosophers--Henriot, 1979. There are, therefore, many variations within the general theme of the structural-institutionalists. The major objective will be to present principle themes relevant to this study, without attempting to present a fullfledged treatise on this model.

This typology evolved out of what its adherents perceived as the gross inadequacies of the Rostowian model in explaining growing inequalities that accompanied economic growth in developing countries. As a knowledge base it played a dominant role in calling for the redefinition of development through the incorporation of

such social indicators as education, health, employment, and housing. Patterns of growing inequalities were gleaned from such studies as those of Adelman and Morris (1973) to which Wilber and Weaver (1979) referred. Findings by these analysts (Adelman and Morris, 1973) alarmed developmentalists because they established a reversal in the trickle down effect. It was affirmed that in most cases there was a trickle up effect, that is, the elite--a minority of about 5% of the population--gained from the benefits accrued without sharing them with the poor. Concern with these findings resulted in a serious debate on what the nature of development should be (Henriot, 1979). Seers (1969) described the overall questions raised by these thinkers, which embodied much of what they perceived as the issues for development. He described these as follows:

> The questions to ask about a country's development are therefore: What has been happening to poverty? What has been happening to unemployment? What has been happening to inequality? If all three of these have declined from high levels, then beyond a doubt this has been a period of development for the country concerned. If one or two of these central problems have been growing worse, especially if all three have, it would be strange to call the result "development," even if per capita income doubled (Seers, 1969: 3).

These questions and concerns caused the analysts to promote the presentation of distribution patterns which would show who benefited from economic growth (Henriot, 1979; Hicks and Streeten, 1979). The discussion became one of economic development rather than economic growth (Wilber, 1979).

Along with equitable distribution, the nature of transformation and adaptations within institutions brought about by the process of development were of particular concern to these analysts. That is, they were concerned with human adaptation to development (Goulet, 1971). Goulet was probably the most articulate advocate of this point of view. In his numerous works --1971, 1977, 1980--he cautioned development specialists against supporting a development strategy that might alter indigenous culture. He was a strong advocate of retaining indigenous value systems by calling for a development strategy that would incorporate spiritual as well as cultural values. He described his reasoning in the following words:

> Inasmuch as the core values of all existence rationalities are designed to nurture survival, basic esteem, and freedom, these values should not be challenged frontally. Such an attack risks being arbitrary and unduly threatening to basic identity. If change is to be welcomed, three conditions must be met: (a) new capacities for handling information must be generated; (b) vital resources hitherto not available must become exploitable; and (c) the alien rationality implicit in "modernization" must be reinterpreted in terms of traditional existence rationalities. Innovation must be rendered compatible with the demands of both present existence and what we may call "expanded" existence (Goulet, 1971: 189).

This implied that development models had to be critically analyzed prior to applying them to any country to ensure that they were indeed compatible with that culture. This advice was applicable to nationals as well as foreigners who fell in the category of what he termed change agents. Very often the pressures of presenting an efficient system of development could, according to

Goulet (1971), result in the total disregard of indigenous value systems often considered non-scientific (Goulet, 1971). Development specialists who overlooked important traditional value systems were termed by Goulet "one-eyed giants," devoid of wisdom. He described the effects of these developers on a society in the following exclamatory tones:

> Small wonder, then that developers have, in society after society, made "things fall apart" (to cite the title of Achebe's novel) or launched fragile communities on what Kane calls the "Ambiguous Adventure" (Goulet, 1980: 481).

References to "fragile" and disintegrating communities were compatible with the theme that distinguished Goulet's writing, that development goals should emerge from indigenous culture and if they did, models of development compatible with local culture would also emerge. Such development was positive because it operated from a position of internal strength which assumed that indigenous culture had the potential to generate growth. The use of foreign models was considered by Goulet (1980) as inappropriate, for it very often resulted in the manipulation of indigenous value systems so that it accommodated the paradigm.

Illich (1979) was particularly lucid on this argument. He defined development models created in the western world as prepackaged solutions. Within these solutions were embodied consumer needs beyond the means of developing countries. For example, Illich (1979) maintained that consumer needs of the elite and middle classes made a substantial dent in the economies of poor

countries. Satisfaction of these needs diverted precious revenue from meeting basic needs--health, shelter and transportation--of the majority of people suffering abject poverty. He maintained that the ease with which the solutions were accepted by national elites was indicative of an alliance forged for the maintenance of underdevelopment, a condition he defined as a state of mind:

> Underdevelopment as a form of consciousness is an extreme result of what we call in the language of both Marx and Freud "verdlinglichung" or reification. By reification I mean the hardening of the perception of real needs into the demand for mass manufactured products. I mean the translation of thirst into the need for a Coke. This kind of reification occurs in the manipulation of primary human needs by vast bureaucratic organizations which have succeeded in dominating the imagination of potential consumers (Illich, 1979: 440).

Such a condition affected thinking in the general population because it denied people the use of their reflective abilities. Dependence on "prepackaged solutions" displaced the people as a viable source from which solutions could be drawn. Consultation on the strategy for development was confined to national and international elites. Advocates of utilizing indigenous intellect in the solution of development problems credited Freire (1974) with a systematic presentation of its rationale (Goulet, 1971, 1980; Illich, 1979). Paulo Freire presented the outline of his approach in a book entitled: Pedagogy of the Oppressed (1974).

In this book Freire outlined some of the major themes with which development should concern itself. They can be summarized briefly as follows:

1. Development should arouse people to reflect about their human conditions.

2. By reflection, people are encouraged to take control of their own lives.

3. Reflection promotes liberation as people are inspired to use their own intellects and become subjects rather than objects of development.

4. Development should stimulate reflection, which was discouraged during colonialism. Freire argued that colonialism stripped people in the developing world of these reflective abilities and by prescription subjected them to the consciousness of the oppressor.

5. By becoming subjects rather than objects of development, people are empowered to determine their own destiny and, therefore, their own development.

Goulet (1980) and Illich (1979) agreed that under Freire's scheme (1974), development not only became more humane but also became less costly. This observation was supported by such third world specialists as Cabral (1973), Cesaire (1972), Memmi (1965, 1968), and Nyerere (1967, 1977). They supported the basic arguments presented under the paradigm thus far, but went a step further to consider what effect development should have on people. In reviewing this body of literature it became clear that the person and not the country was the focal point of their discourse. Their analysis highlighted what Streeten (1972) called the core of the institutional paradigm, which was people. Streeten (1972) in particular was concerned that too much emphasis was placed on discussing developing countries when the discussions ought to have centered on human beings. Constant reference to developing

countries, according to him, created a false emphasis because development was aimed at improving the quality of life for people and not countries (Streeten, 1982).

In discussing the entire question of development, third world members of this school of thought including Freire (1974) were careful to approach it within its historical context. The consensus among these analysts was that many of the problems experienced by developing countries were the result of colonialism, a conclusion drawn from the following observations:

1. Institutional structures inherited from colonialism remain the same today (Illich, 1979; Morris, 1979).

2. The economies of third world countries continued to be bound to those of the developed world.

3. Because of all of the above, the principal aim of development should be to emancipate third world people from the negative consequences of colonialism.

4. Emancipation can be facilitated by a development strategy which is culture specific. Chabal (1981) saw in Cabral's writings a development strategy which fulfills these requirements. Chabal (1981) was of the opinion that Cabral used the Marxist tool but adapted it to his culture, evolving a model that was clearly indigenous.

The overall prescription which flowed from members of this school of thought was that developing countries could only hope to solve their problems if they underwent fundamental institutional transformation (Cabral, 1973; Illich, 1974; Memmi, 1965, 1968). This change could not be confined to institutions but to people, by encouraging them to present solutions that emanated from their

own culture (Goulet, 1971). As mentioned earlier this school represented diverse thinking so that it was not surprising that there were others who gave different prescriptions. Morris (1979) was an example of one who felt that although colonial institutions persisted, the crux of the problem of underdevelopment in Africa was due to incomplete acculturation. He argued that underdevelopment would be less severe in Africa today:

> if the African people had been able to accept and fully assimilate the technology which constituted the armature of western countries, and if they had modified their archaic structures appropriately (Morris, 1979: 227).

As a form of prescription Morris (1979) recommended accelerated assimilation which would enable the nationals--in this case, Africans--to assume the responsibilities of development.

An important theme under this model, which is becoming more and more popular in development circles, is the call for a "Basic Needs" program (Dell, 1979; Hicks and Streeten, 1979; Isenman, 1980; Streeten, 1981). Under this program the major objective was to eradicate poverty. It was a strategy supported by most specialists regardless of political or professional persuasion (Dell, 1979). Although the notion of social equity was upheld more careful attention was paid to the definition of needs. The question asked was, do these expressed needs entail unnecessary sacrifice by a majority of the people? For example, do rural people have to forego clinics so that the city can build a new modern hospital or import expensive equipment (Streeten, 1981)? It implied that the

development process was much more attuned to the edification of indigenous culture as a core of knowledge that could define needs and prescribe their satisfaction. Such a program was more specific. Isenman (1980), probably was not the only one who considered Sri Lanka as a prime example of this mode of development. Isenman (1980) was of the opinion that although Sri Lanka had had its share of problems it had progressed significantly by making health and educational facilities available to a vast majority of the people. It had also made basic Buddhist values (Ling, 1980) the philosophical cornerstone of its development strategy, a step that had enhanced development.

Summary. The eclectic nature of this paradigm tended to create clusters within the overall school of thought. There were those who advocated a "basic need", program and those who argued for structural transformation. The summary presented will give the themes for this paradigm which may be described as follows:

1. The consensus was that Gross National Product was an inappropriate instrument for measuring development. It presented a false impression of the process of development as it focused only on statistical aggregates and did not give a qualitative evaluation of the quality of life.

2. This consensus was reinforced when studies conducted by some adherents of this development approach established a "trickle up" rather than a "trickle down" effect.

3. Development was to be measured more in terms of distribution patterns. Statistics were to show who benefits from economic growth.

4. A more comprehensive approach was to incorporate the development of not just the economic but the agricultural, educational and health sectors.

5. Social equity was to be the goal of development. A vast majority of people should have access to educational, health and employment facilities.

6. All exponents of this model considered change to be inevitable. Nevertheless they emphasized that such change should occur within the framework of indigenous cultures.

7. Institutions were to be transformed to reflect indigenous culture.

8. A basic needs program was perceived as one that could inspire social equity by monitoring the satisfaction of the primary requirements of food, shelter, health care and education.

Criticism of the model. The strongest critique leveled at this paradigm came from the dependency theorists who maintained that the institutionalists tended to look at the process of development as an internal matter to individual third world countries (Henriot, 1979). According to these theorists--Dos Santos (1970), Frank (1979), Cardosa and Faletto (1979)--the institutional structuralists overlooked the vital function of international relations and the incorporation of developing countries into the world economy.

Dependency Model

Overview. A distinguishing characteristic of this model was

in its over-representation by Third World thinkers (Henriot, 1979) such as Dos Santos (1979), Todaro (1981), Bodenheimer (1970), and Amin (1977), who played a significant role in its formulation. Therefore, even if Baran (1979) was considered the original developer of this model, it received its fullest expression through the writings of third world proponents especially the Latin American members. It was often referred to as a Latin American model (Little, 1982). As a group of analysts, these theorists were much more ideologically focused than the structural-institutionalists, making it easier to find a definition of this model acceptable to all. Dos Santos, considered by Bodenheimer (1970) to be a leading proponent of this model, offered this definition:

> The relation of interdependence between two or more economies, and between these and world trade, assumes the form of dependence when countries (the dominant ones) can expand, can be self-sustaining, while other countries (the dependent ones) can do this only as a reflection of that expansion which have either a positive or a negative effect on their immediate development (Dos Santos, 1970: 231).

Characteristics and assumptions of the Model. The overall assumptions and characteristics of the model will be paraphrased from the works of proponents and critics of this model. The body of literature used was as follows: Baran, 1979; Bodenheimer, 1970; Chilcote, and Edelstein, 1974; Dos Santos, 1970; Frank, 1972 and 1979; Griffin, 1979; Little, 1982; Navarro, 1976; and Rodney, 1974. The main points of consensus were:

1. Developing countries were locked in exploitative economic relationships with developed countries, through their historical integration in the world economy.

2. The industrial revolution was instrumental in tying the economies of these countries to those of Western Europe by its expansion into colonial territories, a move precipitated by the need to find new markets for manufactured goods and explore sources of much needed raw materials.

3. The European industrial structure became the center of economic development determining the direction in which the periphery developed. For example, the Caribbean basin (Jamaica) produced sugar while West Africa (Ghana) provided cocoa nuts. A marriage of these two in the manufacturing centers of London produced cocoa which was exported back to Jamaica or Ghana in finished form. The inhabitants of these countries had no access to the skills for producing this item; their function was to produce the raw material for its production (Manley, speech 1981).

4. Therefore, the industrial revolution did much to change the world economy through the restructuring described above (Furtado, 1964).

5. These structural conditions prevailed because, although developing countries acquired political independence they did not obtain economic independence (First, 1981; Manley, 1980, speech Feb. 1981). The structures established during colonialism remain intact (Illich, 1979; Morris, 1979; Manley, 1980).

6. The exploitative nature of this integration demonstrated itself through the continued domination of the growth sector in developing countries by foreign capital and ownership (Pala and Seidman, 1976; First, 1981). Developing countries continued to serve as markets for manufactured goods from the developed world while providing the raw materials. Prices for these goods were determined by the developed market.

7. Underdevelopment was the result of the above-mentioned conditions, i.e., it was a consequence of unequal international economic relations.

8. Internal conditions of oppression helped to create and maintain underdevelopment. Colonial penetration not only restructured economic institutions but developed a new elite who had easy access to educational opportunities and civil positions. Members of the institutional school such as Morris (1979) came to the same conclusion declaring that these elites now governed the developing countries. They formed an alliance with the elites in the developed countries and shared a common economic interest. The nature of this relationship allowed for the protraction of underdevelopment.

Based on these observations, adherents of this model believed that underdevelopment was a historical phenomenon and a function of external economic relations as well as internal relations of inequality.

Underdevelopment could not, therefore, be eradicated through the single act of manipulating internal conditions. Creative measures for its eradication had to be applied to both the internal and international factors that sustained it.

As a prescriptive measure, its exponents called for a "New International Economic Order" (NIEO) which would result in the restructuring of the world economy to reflect more parity in trade.

Criticism. This model is described by Henriot (1979) as having many critics. Some critics such as Little (1982) paid too much attention to its strong ideological base thereby neglecting a fuller discussion of the utility of its conceptual framework. A major bone of contention with this theory was its prescriptive pronouncement regarding the NIEO. Much of the discourse surrounding

NIEO was due to the fact that as a course of action, it was actively or in principle supported by a vast majority of the developing countries (Halsted, 1980; Henriot, 1979). Its principles formed the cornerstone of the agenda proposed by the non-aligned nations (Manley, 1980), a matter of grave concern to the industrialized nations (Henriot, 1979; Smith, 1977).

In conclusion, the principal arguments leveled against this model are presented by Henriot in his overview of this paradigm and the criticism leveled against it. He concluded that the major argument against this model was "that the case is overdrawn and the history sometimes distorted" (Henriot, 1979, p. 12).

Liberation Model

Overview. The distinguishing feature about this model was in its strong patronage by theologians and other members of the clergy. Despite the tendency to look askance at any consideration of religion in relationship to development, organized religion has historically played a vital role in the economic development of developing countries (Von Der Mehden, 1980; Turner, 1980). The missionaries brought with them, according to Wilber and Jameson (1980) a western way of life as well as the desire to proselytize. As an institution, religion embodies the normative structure that dictates the nature of one's relationship to the supernatural and, conversely, to one's fellow beings. It, therefore, mirrors the

precepts of culture in which it evolved, to use Wilber and Jameson's (1980), and Goulet's (1980) term, it reflects the "moral base" of a society.

Wilber and James (1980) claimed that Christianity, through its embrace of the Protestant ethic, significantly altered economic behavior. As a result of this observation, they recommended that the nature of development be defined in relationship with the moral base embraced by indigenous religious precepts--a point which found wide support among some development specialists such as Goulet (1981). World Development, a journal, presented an anthology in its 1980 edition (Volume 8, Number 7/8) devoted to an interesting debate on this subject matter. The overall consensus was that religion was indeed important and should play an integral role in development.

For the purpose of this study, the major concern with religious implications for development will be confined to a review of a particular school of thought, one that blends religious values into a definition of development. This particular model of development, although an offshoot of the French school of thought on development led by economist Francois Perroux, is now almost entirely confined to Latin American thinkers. According to Goulet proponents of this model are a new theologians who:

> Have repudiated all purely spiritualistic conceptions of religion which justify passivity in the presence of oppressive structures. (Goulet, 1980: 486)

This implied that, according to these theologians, true belief in God embraced the need to be fair and to actively remove those obstacles that may hinder the enjoyment of life for others. Poverty, illiteracy, institutional as well as self-oppression were perceived as just such impediments. Gutïerrez outlined the basic assumptions of this model in a book entitled; A Theology of Liberation History, Politics and Salvation (1973). It was from this book that the basic characteristics of this paradigm were derived.

Characteristics and Assumptions of the Model. From Gutïerrez' book the basic characteristics and assumptions of the model emerge as follows:

1. It endorsed the major assumptions of the dependency model, that is, underdevelopment was perceived as a historical phenomenon, sustained by the nature of international economic relations as well as internal problems of inequality. Therefore, the call for NIEO was supported by these thinkers.

2. The Liberationists departed from the dependency theorists by focusing most specifically on people. The overriding concern was with liberation of the human spirit. Liberation was equated with freedom from negative concepts of self internalized by the oppressed.

3. It was the overall assumption in this model that while it was important to overcome the economic, social and cultural bottlenecks to development, such transformation should occur concomitant to the empowerment of people with positive self definitions.

4. Concepts were central to this approach. In line with their overall arguments, these analysts replace the term development with liberation. Development, according to these advocates, accommodated alien models by projecting images of consumerism as the objectives of development. Liberation, on the other hand, pointed more directly to self development and therefore embraced the transformation alluded to in point 3.

Criticism of the Model. The major criticism of this model was inherent in its philosophical precepts. Despite the fact that these theologians paid attention to economic realities their contributions were not taken seriously because of the assumption that their ideas would not withstand the rigors of empirical scrutiny (Goulet, 1971).

Summary. Table 1 provides a brief overview of the models just described. From the review it is clear that the Stages of Growth, a Rostowian development model, differs most significantly from the other three models. It encourages the diffusion of western technology, values and capital, assuming that without them growth is not possible. The implication for human development is that people will have to adapt to a value system perhaps alien to their own. For example some people may state that the critical variable is compatability of the value system in the receiving culture to Western cultures.

The structural-institutionalists recommend a development model that will ensure equitable distribution--one that would be more compatible with indigenous value systems. They are supported by the dependency theorists who perceive underdevelopment to be a

TABLE 1

CHARACTERISTICS OF DEVELOPMENT MODELS

	Stages of Growth	Structural Institutional School	Dependency Model	Liberation Model
Definition of Development	Development is equated with economic growth (GNP)	Development is equated with equitable distribution of GNP.	Development occurs when developing countries decide the course and nature of their development.	Autocentric development should be accompanied by individual freedom to decide their future.
Definition of Underdevelopment	Underdevelopment is illiteracy, poverty and lack of western economic expertise.	Underdevelopment is unequal distribution of national income.	Underdevelopment is the economic domination of poor countries by rich countries.	Same as Dependency model. This model adds that underdevelopment is oppresive.
Prescription	Underdevelopment can be eradicated through more transfusion of capital and western values.	Transformation of the institution to ensure equitable distribution and indigenous values.	Restructure the world economic order to reflect parity in trade.	Restructure world economic order; empower the people so they can assume control of their destiny.

consequence of national and international dynamics. Manipulation of internal dynamics was not likely to eradicate underdevelopment. Adherents of this model claimed that internal transformation of structures was to be accompanied by the transformation of international economic relations to ensure parity in trade. Liberation theorists endorsed the arguments of the dependency theorists but felt that the focus should be on the emancipation of people so that they are free to decide their own future.

In conclusion, it can be said that the proponents of the Dependency and Liberation models are more ideologically focused than adherents of the other two models. The institutional-structuralists share some assumptions with the dependency theorists regarding internal transformations of structures. However, they do not focus on international dynamics which is a concern of the dependency theorists and liberationists.

C H A P T E R III

MENTAL HEALTH THEORIES: AN OVERVIEW

Introduction

An overview of mental health theories was important because it illustrated basic assumptions determining normality and abnormality within specific cultural groups. A critical appraisal of western and African assumptions of health was particularly important because of the interplay between the western and African cultures that come about as a result of economic development. Knowledge of both sets of assumptions regarding personality development allowed for the construction of an appropriate tool of mental health evaluation for Nigeria.

Consequently this chapter will present mental health theories in two parts. The first part will constitute an examination of mental health theory through:

(1) The description of influential western paradigms of human development;

(2) The review of third world specialists' critiques of these typologies as they apply to third world people;

(3) An overview of related literature on traditional medicine.

The second part will be geared to an overall description of two diagnostic categories--schizophrenia and personality disorders --which are often associated with cultural discontinuities. The task will be to describe what these disorders are, how they manifest themselves, and how they are associated with cultural disintegration. Such a presentation of mental health theory will be helpful in building a framework within which the discussion of the Nigerian case study presented in Chapter V will be examined.

Overview

Mental health plays an important role in the lives of most people because it determines the availability of an individual to a collective unit, which is the family, community or society. An individual experiencing good mental health is likely to be more active and make a greater contribution to community life than one who is ill. This dimension of the human condition was often overlooked in development work; strategies for development seldom included a consideration of mental health. Health officials and planners tended to focus on endemic and communicable diseases which were closely monitored, as the major objective was to eradicate them (Quenum, 1968; WHO, 1980).

The overall neglect of mental health issues in developing countries was obvious through the lack of statistics on mental health matters which, in turn, contributed to the neglect of

appropriate plans of action which such statistical documentation would have precipitated. The consequences of this inaction resulted in what WHO described as:

> A vicious circle, i.e., problems are not recognized and diagnosed (or the patient is ostracized and not brought to the attention of the official services), hence there is no information on their extent to justify the need for services, and this in turn perpetuates the myth that there are no mental health problems and therefore no mental health services have to be planned (WHO, 1980: 166).

This observation by WHO described an attitude that persisted despite reports that spoke to a growing incidence of mental illness in the developing world (Collomb, 1972; Harding, 1975; Youssef, et al, 1975; WHO, 1975, 1980).

An important factor to consider, which may have contributed to the neglect of mental health documentation, was the reality that in most developing countries mental health services were incorporated within overall health services. This would imply that if the eradication of contagious diseases was the established priority then mental health issues most likely would be ignored until this objective was met. This overall goal was not met for the Africa region because the tendency had been to adopt Euro-American models which focused on curative rather than preventive aspects of health (Quenum, 1968). Not only were these models ineffective but they were also costly, utilizing high technology which had to be imported (Illich, 1976; Navarro, 1978).

Mental health services were found to be equally affected by Euro-American models. Swift and Asuni (1975) stated that African psychiatrists had historically availed themselves of western treatment methodologies. Indigenous models of treatment were discouraged, resulting in the contemporary hospital-centered system of care which emphasized cure (Collomb, 1972; Erinosho, 1979; Swift, 1972). Collomb was extremely critical of this infrastructure which he labeled as archaic and described as follows:

> Thus broadly speaking, there are at present in Africa only a few prison-like facilities, completely insufficient to meet the demand which, in most cases, is not for care but for custody, i.e., removal of the individual from his family and the community.
>
> This situation has resulted from efforts in technical cooperation and the adaptation in Africa of western methods of proven ineffectiveness (Collomb 1972: 63).

In conclusion it can be said that developing countries have absorbed Euro-American models of mental and other health services in the same way they absorbed economic models--by ingesting the conceptual framework which dictates action. For example, the emphasis on bed capacity and the ratio of physicians to the population was considered by Navarro (1976) a good example of the process of imitation that developing countries were engaged in. Emulation of developed countries has had negative consequences for health services which can be summarized as follows:

(1) Western methods emphasize a curative rather than a preventive system of care.

(2) The use of technology results in a capital intensive rather than labor intensive models.

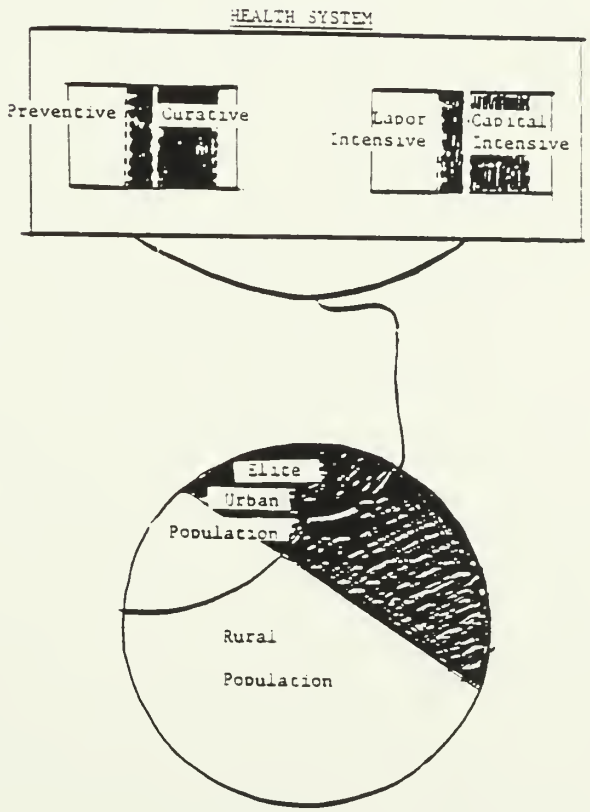
(3) Urban communities are favored above rural communities because the facilities are physically located in urban areas (Navarro, 1976; World Bank, 1980).

These structural characteristics of health services in the Third World were considered negative for developing countries by both The World Bank (1980) and Navarro (1976). They were deemed inappropriate for such societies because the majority of the people in the developing world lived in the rural areas. Consequently the concentration of health services in the urban areas resulted in the total neglect of rural communities. As a result, a large majority of the population went without basic health care. The extensive use of technology compounded the problem because much of the health care budget was spent on the procurement of expensive hospital equipment which could only reach a few.

These characteristics are depicted on Diagram 1 which gives a graphic portrayal of health services in developing countries. This diagram by Rifkin and Kaplisky (1973) was chosen in order to dramatize the discrimination of rural communities by health in Third World countries in favor of urban and elite population groups. According to this diagram, health services seem to foster expensive modernization which made them capital intensive. The orthodox nature of these services made them concentrate on treatment issues rather than prevention (Quenum, 1968).

Diagram 1: Paradigm of Health and Medical Care

In a Typical Undeveloped Country



Source: Rifkin, S.B. and Kaplinsky, Raphael, 1973, p. 215

The following section will focus on a discussion of western paradigms of mental health which have influenced mental health care in Third World countries. Western approaches to the study of mental health can be characterized by both the psychological and sociological models. The western models discussed in this study represented the universal concepts of mental health, that is, the international language of psychiatry. Of equal importance was a closer examination of the African traditional concepts of mental health. The African assumptions of health were critical because they formed the guidelines for a clearer comprehension of the African concept of mental health. The African perspective was central, in the final analysis to evaluating the impact of economic development on mental health in Nigeria.

Mental Health Theories

Introduction

An understanding of the basic assumptions of mental health theories was critical and permitted the discussion of a dialectical relationship between economic development and mental health, that is, the implications of various economic models for mental health. More specifically the economic models presented in Chapter II portrayed idealized economic and social conditions which could be created through the manipulation of one or more factors in the

social structure of a people. Such manipulation would result in a new social reality requiring differing degrees of adaptation. A review of mental health theories allowed the discussion of what these idealized conditions would mean for mental health of a people so affected, that is, a more predictive approach of what human adaptation would look like under these new social conditions. The presentation of both sets of theories, mental health and economic theories, permitted an analysis of the dynamic interplay of mental health and economic development.

For the overall discussion in this section it was important to differentiate between form and content in mental health. Form embraced mental health facilities and resources while content defined the clientel and their eligibility for services, that is, it described psychopathology and its vicissitudes--how and by whom it shall be treated. In short, it embodied the assumptions which underlie normality and abnormality.

There was an important relationship between western assumptions of human behavior and non-western systems of thought. Draguns (1973) and Higginbotham (1979) agreed that indigenous perceptions of mental health have been affected by western modalities of human behavior. In reviewing this question Higginbotham (1979) concluded that training mental health specialists in western countries ensured the continued influence of western philosophies. Through this training these specialists become favorably disposed to western assumptions and, in turn, influenced others in their

home countries. Draguns (1973) came to a similar conclusion in his review of transcultural psychiatry. He described the influence of western paradigms on non-western cultures in the following manner:

> From the day of Kraepelin (1904) to the present (Kiev, 1972; Pfeiffer, 1970), the predominant orientation of crosscultural investigations of psychopathology has been a psychiatric-medical one. This orientation rests on the assumption that psychological disturbance is a disease, in either a direct or a metaphorical sense of the term. Accordingly, it is held that the basic varieties of mental illness have been discovered by the pioneering contributors to descriptive psychiatry. The task of transcultural psychiatry remains to record and describe the manifestations of disturbed behavior in foreign lands and to fit them into the pre-existing and presumably worldwide categories of psychiatric classifications (Draguns 1973: 14).

This implied that even in transcultural psychiatry where the objective was ostensibly to define aberrant behavior in indigenous terms, western paradigms of human behavior continued to serve as the basic instruments of measurement.

The most dominant western model of measuring mental health is the medical model. This model tended to dismiss cultural relativity in diagnosis, because the basic assumption was that the core of mental illness was universal-in terms of western methodology. Kraeplin, the founder of transcultural psychiatry, adhered to this notion of inclusiveness which explained the persistence of the medical model in the evaluation of mental health in non-western cultures (Ihsan, 1982). It was for this reason that a closer perusal of these western assumptions was presented.

The literature on Orthopsychiatry although multidisciplinary in nature, was not fully explored because it did not focus on the particular circumstances of Third World countries.

Psychological Paradigm

The psychological paradigm has influenced thinking about human behavior since the nineteenth century. Through the writings of Sigmund Freud over a period of forty-five years, it has evolved into what is known today as psychoanalytic theory.

Overall assumptions and characteristics. The basic assumptions were:

(1) That there is a structural organization of personality composed of three component parts. Personality integration is dictated by the internal balance of these structures (Maddi, 1976; Yankelovich and Barrett, 1971).

(2) Adult behavior, normal or abnormal, is determined by childhood experiences. The psychological paradigm assesses mental health as the consequence of positive personality development marked by the successful resolution of developmental tasks. Mental illness is the result of unresolved childhood issues or repressed childhood traumas.

Under such view of personality development the basic assumptions about mental health have been:

(1) That mental health was a function of internal psychic balance (Maddi, 1976).

(2) That sociocultural factors became unimportant because personality dynamics are considered universal, transcending cultural boundaries (Deutsch and Krauss, 1965).

Application to developing countries. Through the training of mental health specialists in institutions which promulgate it, this method has had an effect on people in developing countries. That is how they were perceived by such people as Mannoni (1956) who suggested that Africans needed a colonial relationship in which to develop a dependent relationship to Europeans. Africans actively sought such a relationship because they had not yet evolved beyond the "childhood" stage. Fanon, a Martinican psychiatrist schooled in psychoanalytic theory, rejected this notion. He claimed that the alleged dependency of Africans to Europeans happened as a result of the colonial economic circumstance. In most social milieus, Africans had to take their directions from the colonial masters because they were operating in an unfamiliar cultural milieu. Fanon further questioned the relevance of this theory to developing countries because it embodied western culture which, according to him, was often at the root of psychopathology suffered by third world people (Fanon, 1967).

On a more marginal level, Freire (1974) displayed some influence of psychoanalytic theory through the extensive deployment of its terminology. For example, he used the term "identification with the aggressor" as a central concept. More importantly, he imported it with the same meaning as did Anna Freud (1966) when she originated it. "Identification with the aggressor" meant to both a condition where an individual internalized negative behavior patterns of another so that he/she began to mirror the other

behaviorally. The traits internalized were usually negative in nature. For Freire, the situation evolved in a colonial relationship, while for Anna Freud these behavioral tendencies were acquired in a more direct interactional relationship.

In conclusion, it can be said that the psychological paradigm has permeated psychological thinking about human behavior since its inception. Third world people are exposed to this modality either as clients or as professionals.

Sociological Model

The sociological model focused more intently on human interaction rather than on individual intrapsychic balance. Exponents of this paradigm were concerned with the social determinants of human adaptation. Mental health and mental illness were perceived in terms of the interaction between the person and his/her social milieu--more specifically, in relationship to role performance (Deutsch and Krauss, 1965; Parsons, 1981).

Characteristics of the Paradigm. This approach to mental health has often been termed the role theory (Deutsch and Krauss, 1965) because role performance became the central focus. Parsons offered a definition of mental health under this model which embodied its major assumptions when he described mental health and mental illness as:

> States of the personality defined in terms of their relevance to the capacity of the personality to perform institutionalized roles (Parsons, 1981:59).

Fulfilling role obligations meant meeting expectations attached to roles by a particular society. This implied that in an integrated unit all members were aware of what is expected of them in a specific role. Lines of communication were clear.

Although this approach to personality development is highly influenced by sociologists, it still remains under the influence of psychology. Rose (1968) referred to it as psychiatric sociology because it came about as a result of general dissatisfaction with curricula offered training psychiatrists. Some members of the profession were of the opinion that medical training ill prepared the psychiatrist to deal with the phenomenon that was partially social in nature. They called for a more macrocosmic approach to mental health.

The sociological paradigm does not deny the uniqueness of the individual, that is, the innate potential with which everyone is born. It does, however, study more closely the cultural impact on individual behavior (Hewitt, 1979). The overall impact of this paradigm on developing countries will be presented through a description of studies undertaken in the third world, which focused on the effect of modernization on human behavior. There was consensus that development had a modernizing influence and, in some cases, the feeling was that this aspect of development must be successfully concluded for economic development to be attained

(Inkeles and Smith, 1974; Korten, 1972). Inkeles and Smith (1974) Study were of the opinion that the development failures of the early sixties were largely due to the persistence of traditional behavior. They described their observations in the following words:

> Mounting evidence suggests that it is impossible for a state to move into the twentieth century if its people continue to live in an earlier era. A modern nation needs participating citizens, men and women who take an active interest in public affairs and who exercise their rights and perform their duties as members of a community larger than that of the kinship network and the immediate geographic locality. Modern institutions need individuals who can keep to fixed schedules, observe abstract rules, make judgments on the basis of objective evidence, and follow authorities legitimated not by traditional or religious sanction, but by technical competence (Inkeles and Smith 1974: 4).

The implication in this statement was that for economic development to be successful, behavior had to change from a traditional to a more modern orientation. This was a point of view held by other sociologists such as Berger (1971). According to this perspective, the most important constraining factor to economic development so far has been the basic psychological orientation of people in the Third World through their belief systems, customs and traditions which favored values of affiliation and communal life above achievement and self orientation.

Based on his experiences in Africa as well as the literature he reviewed, Korten (1972) concluded that in addition to changing attitudes development changed the thinking of those affected. The review of modernization literature suggested that economic

development can only come about through more complex organizational structures supported by more complex thinking not contained in traditional cultures.

As a region, Africa has had its share of psychological studies. The following examples lend credence to the hypothesized relationship between pressures emanating from development and mental health. It appeared as though studies undertaken in the African continent showed that value conflict resulting from the dominance of western culture caused problems of adjustment for a number of people.

For example Field (1958), in a study in rural Ghana, observed a positive correlation between the growth in the cocoa industry and increased visits to traditional shrines. Field (1958) concluded that growth in the cocoa industry gave people a sense of insecurity which resulted in their increased visits to the shrines. The shrines symbolised traditions with which they were familiar. Collomb (1973) made a similar observation in Senegal when he found an increase in psychosomatic symptoms among urban men. This was an important factor considered crucial for African psychiatry by Baasher (1965) who observed that psychosomatic symptoms often masked serious mental illness in Africa.

These studies treated the issue of mental health problems as a peripheral function of economic development. Investigations which established a more direct relationship between mental health and aspects of development for the Africa region were the studies

by Leighton, et al (1963) and Inkeles and Smith (1974). These studies were concerned with the effects of urbanization on mental health. The Leighton, et al (1963) study concluded that urbanization resulted in a form of cultural change deleterious to mental health. Inkeles and Smith (1974) qualified the findings of the Leighton, et al (1963) team by stating that urbanization does not necessarily adversely affect mental health. These arguments and counter-arguments will be more fully explored in the section that follows.

There are numerous other fact-finding projects worth mentioning which have a bearing on this study. These were the explorations which discussed the problems of cultural alienation as a function of formal education in Africa. Amer (1970), in a research on Nigeria, concluded that the alienation that ensued as a function of formal education evolved more as a result of frustration from unmet goals rather than as a function of value conflict. Leighton, et al (1963) were of the opinion that some alienation came about as a result of value conflict. They argued that an individual who went through formal education very often absorbed a modern value system which elevated, for example, scientific knowledge above traditional wisdom. Schooled in this new value orientation he/she very often questioned traditional values, causing anxiety in village. Finally, Holsinger and Theisen (1977) established a positive correlation between formal education, modernity and national development. It can be said that although

the whole question of mental health in Africa has not been fully explored, evidence suggests that it is an important missing link in understanding the process of national development.

Related Studies. Research projects alluded to in the above discussion will be more closely examined because they clarify some of the qualitative questions raised in the study. For example the Inkeles and Smith study (1974) pointed out the attitudinal requirements for a successful development program, while the Leighton, et al (1963) research pointed out some of the negative consequences of such attitudinal change for mental health.

The Inkeles and Smith (1974) study is probably the most widely published Research in connection with the effects of modernization on human adaptation. The overall objective of the study was described by Inkeles and Smith (1974) as the desire to settle the theoretical dispute existing in literature regarding the effect of modernization on human adaptation. There were those who were convinced that modernization had a negative impact on mental health while others affirmed that modernization had a positive impact on mental health. The central questions posed were:

(1) Does mental health decline in the face of rapid modernization and migration?

(2) What makes people modern?

For their investigation Inkeles and Smith selected six developing countries: Argentina; Chile; India; Israel; Nigeria; and

Pakistan. These sites produced an overall human sample of 5,503 men ranging in age from 18-32 years. Their educational level was between 0-8 years of schooling. The sample breakdown is reflected in Table 2.

The requirement for a site selection was that the country be politically stable in addition to experiencing modernization. Institutional modernization was particularly important because the research was heavily dependent on cooperation with local universities. Ibadan, a university town in Nigeria, was selected as a site because of its academic history.

The Psychosomatic Symptoms Test (PT) was chosen as an instrument of measuring mental health after having established that it had been successfully utilized in other investigations representing culturally diverse groups. Examples of surveys referred to are the Midtown Manhattan Study (1962), Psychiatric Illness Among the Yoruba, Leighton, et al (1963) and an "Index of Symptoms and Disease in Zulu Culture" (Scotch and Geiger, 1963/1964).

To explore the second leading question, the researchers defined education, city dwelling, migration, factory work and exposure to mass media as modernizing social structures.

A discussion of these findings should be prefaced with the remark that Inkeles and Smith did not perceive modern behavior as a prerogative of any one specific culture. Consequently, they did not actively pursue a culture-specific scale of modernity because

TABLE 2

Sample Breakdown for Inkeles and Smith Study

Country	Argentina	Chile	India	Israel	Nigeria	Pakistan
Case Count	815	931	1300	736	720	1001

Source: Inkeles and Smith, 1970, p. 86.

they perceived modernization to be a universal phenomena. Although field directors were encouraged to include cultural variance in the definition of modernity, the overall scale used remained the same for the six countries. The Indian field director made some modification which, in the end, showed no significant difference from the original scale (Inkeles and Smith, 1974). Such uniformity gives a false impression of cultural homogeneity.

Modern attitudes and behavior as a critical integral part of the process of economic development formed the central argument of the Inkeles and Smith (1974) research. Their conclusion was based on their overall conviction that modern attitudes:

> are not a marginal gain, derived from the process of institutional modernization, but are rather a precondition for the long-term success of those institutions. Diffusion through the population of the qualities of the modern man is not incidental to the process of social development, it is the essence of national development itself (Inkeles and Smith, 1974: 316).

Inkeles and Smith perceived the modern behavioral repertoire as an essential basic ingredient for economic development. The behavioral characteristics described earlier in this chapter (Inkeles and Smith, 1974: 4), although defined by these researchers as culture-free were, over-represented in the western cultures. Paradoxically some of these vital attitudinal requirements for economic development were inimical to the holistic African cultural orientation which valued collectivism and communal life guided by experience rather than scientific knowledge.

Despite these existing contradictions between the modern and African world views the overall findings of these investigators were that there was no causal relationship between mental illness and modernization. However, mention must be made that for Nigeria it was found that improved education, that is more literacy, did not necessarily have the hypothesized positive effect on mental health.

The Inkeles and Smith (1974) research would fall under basic sociological studies. In contrast, to the Stirling study which falls more in the realm of epidemiological studies aimed at establishing a causal relationship between environmental factors and psychopathology. It was also an important piece of research to consider in this study because it formed the basis for cooperation between North American and Nigerian mental health specialists in a later study of Nigeria.

Leighton described the overall purpose of the study as the need to examine and uncover "something about the influence of socio-cultural factors in the origin, course and outcome of psychiatric disorders" (Leighton, et al 1963:7). The total sample was composed of 1,010 adults, 463 men and 547 women. The sample was drawn from Stirling county, a rural area in Canada.

To classify people into diagnostic categories the Leightons used the 1952 edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Using this manual, they established four degrees of mental illness, which they referred to as Groups A, B, C, and D.

Group A was composed of people who were obviously mentally ill. That is, they had a history of hospitalization, had a nervous breakdown or described clear psychiatric symptomatology. They were hallucinating or were experiencing delusional symptoms.

Group B constituted marginal or borderline cases: people who reported psychosomatic symptoms and sociopathic behavior. Symptomatology in this group was extremely diffuse. The Leightons were of the opinion that 70% of those classified as group B were, in real terms, suffering from psychiatric illness.

Groups C and D were composed of people who had very little chance of developing psychiatric disorders.

Clinical data was obtained through interviews with psychiatrists. This information was supplemented with information obtained from physicians, community members and other related institutions. Psychiatrists were involved in rating the degree of illness.

The findings of this study are presented in Table 3.

In describing the overall findings Clausen (1968) was of the opinion that the Leightons estimated that over half of the population studied qualified as psychiatric patients. Furthermore, the study established that migration caused socio-cultural disintegration and very often preceded the onset of psychiatric illness.

Research on the Yoruba represents perhaps the only extensive epidemiological investigation in Nigeria and probably in independent Africa. It is described in a book entitled Psychiatric

TABLE 3

Stirling Study Findings
Along Diagnostic Categories

Number of respondents	Men 463	Women 537
Classification		
A	21%	40%
B	26%	25%
C and D	53%	35%
Significantly Impaired	31%	33%

Source: Adapted from Psychiatric Disorder Amont the Yoruba, Leighton, et al, 1963, pp. 149

disorder among the Yoruba: A Report from the Cornell-Aro Health Research Project in the Western Region, Nigeria, Leighton, et al, 1963.

The Yoruba study came about as a result of the attention Lambo's research was attracting in international circles. Lambo, a Nigerian psychiatrist, founded the Aro therapeutic village in 1954 for the treatment of the mentally ill. In treating the mentally ill, he combined western techniques of psychiatric care with indigenous methods by using traditional healers in the diagnosis and treatment of patients. The village differed from other psychiatric facilities in that it provided the patient with easy access to neighboring communities and family members. Family members were encouraged to accompany a patient to the village and stay with him/her for the duration of the treatment. Next to the village was Aro hospital, an inpatient clinic and predominantly western in orientation.

Many of the assumptions in this study were drawn from the Stirling research. The overall assumption was that the higher the degree of disintegration in a village, the higher the incidence of mental health problems. The major objective was to examine the prevalence of psychiatric disorder among the Yoruba.

The same diagnostic categories A, B, C and D used in the Stirling study were used in this investigation. These groupings were modified to ensure representation of Yoruba culture.

The village was the unit of study and was classified into three categories:

(1) Integrated Village

An integrated village was defined as one distinguished by family stability, respect for traditional mores and community leadership and less poverty.

(2) Disintegrated Village

A disintegrated village was one experiencing a great deal of poverty, family instability characterized by nontraditional lifestyles accompanied by the diminishing influence of traditional authority.

(3) Intermediate Village

As the name indicates, such a village would be one that manifests a mixture of integrated and disintegrated characteristics.

Poverty was not the defining denominator for establishing disintegration. The researchers were concerned with the process of disintegration as it manifested itself through the diminishing influence of traditional values on people's behavior. The fundamental questions raised were those related to the nature of cultural cohesiveness. Leighton (1967) in a later article reflected that poverty may coexist with social disintegration but it was not necessarily its determinant.

The human sample totalled 485 with 262 drawn from fifteen villages around Aro Village, 64 from Abeokuto city, and 59 from the Aro hospital. The villages had a population ranging from 37 to 2,130. The major reason for drawing from the hospital

population was to present the existent pattern of psychiatric illness in the area. Table 4 gives a sample breakdown.

The actual study was preceded by a period of "retooling", during which much attention was devoted to redefining concepts to fit the Yoruba perceptions of human development. This process was undertaken under the guidance of Lambo, who involved traditional healers in concept definitions.

The Psychosomatic Symptoms Text (PT) was adapted to include parts of social reality unique to the Yoruba culture. The PT test began to incorporate concepts of supernatural beings. Furthermore, words such as "Iwaro" meaning agitation, were included in the test. Interviews were conducted by trained Yoruba and the Leighton team. Translators trained especially for this task were available.

An important finding in this study was the lack of psychiatric morbidity in respondents over the age of sixty. The researchers concluded that this state of affairs was attributable to Yoruba culture which perceived senility as a natural process of aging. Psychiatric symptoms were found more among men than women. Findings along diagnostic classifications are shown on Table 5.

The overall findings in the hospital group bore out the belief that regression was less severe in African psychotic patients. Furthermore, the presence of psychosomatic ailments in the non-hospital group validated the Baasher's (1965) contention that psychosomatic symptoms masked a great deal of psychiatric ailments in Africans.

TABLE 4

Leighton, et al Study Sample Breakdown

	Yoruba Villages	Abeokuta City	Aro Hospital
No. of Respondents	15 Villages 262	64	59
Sex			
Men	138	32	27
Women	124	32	32

Source: Adapted Leighton, et al, 1963, p. 125

TABLE 5

Research finding for Leighton et al Study
Along Diagnostic Categories

	Hospital	Non-Hospital
Number of Respondents	59	326
Rating		
A	92%	23%
B	8%	17%
C and D	-	60%
Significantly Impaired	69%	16%

Source: Adpated from Leighton, et al, 1963, p. 134

This study has been labeled as inappropriate by Inkeles and Smith (1974) for providing a positive correlation between mental illness and urbanization. The invalidation of this finding was based largely to their own findings (1974). The validity of this disclaimer should be considered in light of the following characteristics of the Inkeles and Smith survey:

(1) The survey covered a wide geographic area representing numerous cultures and subcultures.

(2) Although allowances for cultural specificity in definitions were made, they were left up to the field directors to explore and were not actively pursued.

(3) The concept of modernity was treated as a universal concept.

(4) The sample concentrated on men already in the developing sector and excluded women and rural people.

The Leighton, et al findings would appear to be in keeping with studies mentioned earlier such as Amer (1970) and Field (1958) which found increasing alienation alongside economic development in Africa. It is not possible to discard these findings for the region.

These inquiries have illustrated a more comprehensive approach to mental health. Sinha (1975), an Indian psychologist, was of the opinion that the sociological model was the only approach appropriate for the study of human adaptations in developing countries. He was particularly emphatic about developing Indian concepts rather than adapting western concepts to Indian culture, a matter of particular concern in the Leighton, et al (1963), study.

Summary. These research studies embraced the sociological model which assumed that organizations or institutions were part of the total social structure (Bryant and White, 1982); that is, these structures (Inkeles and Smith, 1974) embraced socio-cultural environments (Leighton, et al, 1963) which embody human interaction. Changes in these institutions had an effect on interactions because they changed the nature of expectations inherent in specific roles. For example, the Leighton, et al, 1963, study found that in integrated villages, change through urbanization did not result in rejection of traditional behavior. Respect for elders and traditional authority persisted. In disintegrated villages, however, the system of rewards changed at the socio-cultural level. Traditional authority diminished, shifting rewards to the more formally educated. Family and group ties became less meaningful, leaving the individual with very few support systems.

The interconnectedness between the social milieu and mental health was the focus of a task force ordered by the National Institutes of Mental Health (NIMH) in the United States as late as 1977. The results of their findings were published in Vol. 16, No. 1, Spring edition (1980) of the Community Mental Health Journal. The overall impression by members of this task force was that "The way people perceive their surroundings influences the way they behave in that environment" (Insel, 1977:76). In conclusion, it can be said that the quotation above adequately described the interconnectedness of socio-cultural environments and human interaction examined in the studies presented.

Traditional Philosophies of Health and Disease

The presentation of traditional concepts of illness and health will be brief and will be drawn mainly from the following sources of literature: Corin and Bibeau (1980); Jackson (1976); Okwu (1979); Onwuanibe (1979); Rappaport (1977); and an anthology edited by Ademuwagun, Ayoade, Harrison and Warren (1979) entitled The African Therapeutic Systems. The latter piece of research will be used extensively because it covered works on traditional healing over most of the African continent.

Traditional medicine has been found to play an important role in the lives of most Africans, be they literate or illiterate (Erinosho, 1979; Rappaport, 1977). Rappaport, in an extensive study of traditional healers in Tanzania, concluded that the healers were sought out because they shared the same "world view" as their patients. The treatment they applied made sense to the patient because it evolved from the same philosophical base as that of the patient. The African "world view" will be summarized from the above-mentioned works as follows:

(1) The overall consensus in this literature was the recognition that in African folklore there was no dichotomy between the spiritual, mental and physical world. To the African the three spheres of life were in dynamic interaction. Ayoade described this interchange in the following words:

> A non-supernatural and supernatural ailment are only different points along the same continuum. The headache of a patient may be non-supernatural in the morning but supernatural in the evening (Ayoade, 1979: 49).

(2) This cosmic fusion had important implications for diagnosis. In most cases, disease was perceived as the individual's violation of cultural norms for which he/she was being punished by ancestors. Dawson (1977), in his research on mental illness in Sierra Leone, concluded that the "curse" was the mechanism whereby ancestral spirits made their presence felt. A cursed individual was one more likely to fall ill, physically or mentally.

(3) An important derivative of this philosophical approach was the belief that the mentally ill person could represent ancestral disapproval with the entire community. This belief made the community cooperate with the healer.

(4) The importance of family was expressed through its extension into a community concept toward which each felt responsible. Okwu described the communal spirit as follows:

> Each member of the community has rights and responsibilities. Consequently, an individual member's illness is seen as a disruption of the integrated social responsibility of the community, as well as a signal of the super natural's displeasure with a member of the society, a displeasure that may later spread to the total society if it is not controlled (Okwu, 1979: 22).

Along the same lines, Jackson (1976) spoke of the primacy of the group in the African tradition. This implied that the individual found true meaning in community participation. What were the implications of this approach to mental health?

(1) Baasher (1965), recognizing the cosmic fusion in his work in East Africa, observed that orthodox psychiatry could never be successful unless it learned to incorporate this fusion in its approach to African psychiatry. Somatization of affect which manifested itself through the extensive display of psychosomatic symptoms was, according to him, a demonstration of this cosmic belief system.

(2) Treatment, in the traditional sense, was comprised of recognizing the symptoms but, above all, understanding why the individual suffered from the presenting ailments.

(3) Treatment was holistic, taking into consideration the physical, mental and spiritual.

(4) The overall objective was to reintegrate the individual into his/her community.

(5) The consensus in the literature is that treatment was individualized with each patient getting "costume cut" therapy specific to him/her. Potions were mixed in the patient's presence, giving the client undivided attention (Rappaport, 1977).

(6) Nosological issues were not very important to traditional healing (Leighton, et al, 1963).

It was in its holistic approach and its embodiment of traditions through its healers that traditional healing in Africa has withstood the test of time. Ohrn and Riley (1977) affirmed that the historic concern with traditional healing by westerners was born out of the desire to displace it. In post-Independence Africa, traditional healing found itself again in confrontation with the western system (Ademuwagun, 1977); public health facilities were expanded without incorporating traditional healing. Various African mental health and health specialists have advocated the inclusion of traditional healers in health services (Ademuwagun, 1977; Lambo, 1960).

The above presentation of African health concepts has shown an emphasis on values of affiliation that is, group and community membership punctuated by a keen awareness of spiritual life

dictating behavior. The interconnectedness of these three spheres --mental, physical and spiritual is what distinguished the African construct of health from the western paradigms discussed earlier.

Anyanwu, a Nigerian philosopher, succinctly described the African cultural philosophy as:

> A loyalty to life, to living process, to values and to faith not to any system or school of thought. It denies all forms of dualisms. As a unitary view of reality, it sees process as having one general form of continuity. Process is never sacrificed to static permanence. Within this general process, there are purpose and necessity (Anyanwu, 1981: 76).

According to Anyanwu the African philosophical orientation is ingrained in the individual through the individual's constant reference to the unity of man and nature. More importantly, Anyanwu indicated that although the African philosophy emphasized a communal approach it does accept the uniqueness of individuals.

Of critical importance to this study was Anyanwu's observation that African dress, music and dietary habits did not constitute the African philosophy described above. They were the artifact of a culture, not the center of its philosophical base. The principles governing behavior in African cultures were those of a cosmic universe.

Third World Perspectives on Euro-American Paradigms of Mental Health

This section of the study will be devoted to the review of literature by third world mental health specialists who discuss

the applicability of western psychiatry to developing countries. Included will be the work of those western mental health specialists who have been strong advocates of an indigenous system of psychiatry in Africa (Draguns, 1973; Higginbotham, 1979; Rappaport, 1977). There is yet another body of literature which has been strongly critical of the application of western psychiatry to minority groups without modification. The overall argument by these scholars is that, although minorities are domiciled in the western hemisphere, their social circumstances are not western, particularly not white. Speaking of the American black, Noel (1974) quoted Mosby as follows:

> The personality of the black person is molded, determined, shaped by a dominant and generally adversive cultural influence. As a result of continuous repressive restrictions and inferiority perceptions, he internalizes inadequacy (Mosby, 1972: 125).

This body of literature will be utilized when it clarifies arguments presented by the first group. There are, however, some specialists in this latter group such as Bulhan (1979, 1980) and Jackson (1976) who have made the connection between the black experience abroad and African traditional belief systems.

In addition to mental health specialists, the works of third world development specialists such as Cabral (1973), Cesaire (1972), Freire (1974), Memmi (1965, 1971), and Nyerere (1974) will be included.

Frantz Fanon. Fanon made an invaluable contribution to third world psychiatry through his writings (1967, 1967, 1968). His

academic training was in classical psychoanalytic theory in France --a bias that was particularly evident in his first book titled Black Skin, White Masks (1967).

Fanon developed his overall approach to psychiatry through his contact with third world patients in the Metropolis, Paris and Algeria. He was confronted with African and Martinican patients throughout his residency. These contacts made him increasingly aware of the inadequacy of western psychiatric tools in capturing or explaining mental health problems of third world people. His struggle with psychoanalytic theories was particularly evident in the first book mentioned above. In this book, he redefined terms such as neurosis in social psychological terminology by including social variables; that is, he perceived neurosis as a result of the interaction between the personal and environmental factors (Fanon, 1967). His radical departure from psychoanalytic theory was contained in the same book in his denunciation of the Oedipal complex. He declared with pride that Martinique could not produce one incident of the Oedipal complex, which was central to psychoanalytic theory assumptions on human development.

In his opinion, the psychopathology of third world people was a consequence of the oppression they suffered under colonialism. Parallel with this argument, Fanon maintained that the mental health of third world people was to be studied within its "essential historical coordinates" (Bulhan, 1980), implying that colonialism played a significant role in shaping human dynamics.

According to Fanon (1967) the imposition of western culture through colonialism was tantamount to the redefinition of human behavior.

The traditional family found itself in competition with formal education as a primary socializing agent because it did not have the kills to pass onto its members for effective functioning in the dominant sector. This interaction between the western and traditional culture, in which the former was dominant, created feelings of inadequacies among the colonized. These emotions were further heightened by the equation of white with goodness and black with badness (Fanon, 1967; Bulhan, 1980). Anxieties were intensified when third world people recognized that no matter to what degree they assimilated, they could never be truly accepted (Fanon, 1967). Fanon illustrates this with Martinicans and Africans in Paris who found to their disillusionment that their French could never really be perfect.

This relationship with western culture created an external definition of self, one that is consistent with European culture and not with indigenous culture. This external definition of self persisted, according to Abdullah (1977), into contemporary times (Bulhan, 1979). Abdullah, in a study of self-esteem in Nigeria, concluded that girls who defined themselves by a traditional mode had a healthier self-esteem than those who defined themselves by western standards. For example, the latter group would define themselves by highlighting intelligence rates. Bulhan (1979), in his work with African students, found that some often came to the

United States in search of selfaffirmation. The disillusionment that often ensued precipitated mental illness for this group of students when the visualized image of selfaffirmation associated with western culture did not unfold. Bulhan was of the opinion that such preconceived ideas were the result of successful European indoctrination of the elite during the colonial era. He described this in the following manner:

> From an economic viewpoint, they (the elite) have become the hoarding consumers, if not the efficient producers, for which they were long ordained. From the political standpoint, Europe and its American diaspora found a cadre of loyal auxiliaries who, to this day, perpetuate oppressive structures and manipulate the African masses. From a psychological viewpoint, using the defense mechanism of 'identification with the aggressor' this cadre has readily internalized the oppressor's ideas, values and social behavior. A psychological atrophy and absence of creativity became the hallmark of these auxiliaries. Everywhere we turn in the black world--in Africa as in the Caribbean, in North America as in Brazil--we find the same cadres of auxiliaries (Bulhan 1979: 244).

This was a point of total agreement between Fanon's conceptualization of mental health of third world people and third world development specialists' evaluation of the course of underdevelopment. Bulhan (1979) encapsulated it all very neatly in the above quotation. The point of agreement was that underdevelopment lay in the mind which had not relinquished western traditions. The implication of this assessment was that relationships of dependencies perpetuate colonial behavioral patterns.

Fanon (1978) and Bulhan (1979, 1980) operated from the premise that these dependencies can be reversed. Fanon (1967) depicted how

this can be accomplished by discussing how the Algerian revolution went about ejecting the French mentality, through the enthusiastic adoption of indigenous patterns of behavior such as women's return to the veil. This was an outward manifestation of the internal process of self definition through indigenous precepts.

It was clear from this description that Fanon saw western psychiatry as an outgrowth of a culture which he perceived to be pathogenic to third world personality development.

Asuni (1975), Binite (1977, 1979), Doi (1978), Erinosho (1977, 1978), Jackson (1979) and Lambo (1955, 1960) formed a group of mental health specialists which was more contemporary and which gave a current appraisal of thinking on western psychiatric modalities. It can be said that there was a consensus among them that western constructs were to be applied with extreme caution and, wherever possible, indigenous models were to be developed. Doi (1978), a Japanese psychiatrist, was included because his work illustrated most lucidly the inappropriateness of western constructs of mental health for non-western cultures. Japan is by no stretch of the imagination a developing country, but it is not, culturally speaking, a western country. Despite the inclusion of Doi, the selection of mental health specialists leans towards the African specialists because the study is on Africa. However, Africans were by no means monolithic and there were African psychiatrists such as Ndetei (1980) who advocated the incorporation of traditional western psychotherapy in Africa.

Discussion. Doi (1978) was of the opinion that language was a dominant factor in culture and that concepts should evolve from indigenous language. Language according to Doi embraced the essence of a culture and should be used in formulating each culture's psychological test. It was inconceivable to Doi that western language could actually capture the Japanese soul. Lambo encouraged the incorporation of Yoruba terms of significance in the PT test used in the Leighton, et al, (1983) study to ensure that the essence of certain behavioral meanings was captured.

Along the same line, Sinha (1975), an Indian psychologist, insisted that tests in developing countries should evolve from the culture, and that psychologists should stop translating Euro-American concepts. These two points are related and draw most heavily on information provided by the science of linguistics. Pertinent to these arguments was the notion that language projects a mood. True communication of these feelings would be difficult to transmit or evoke in an alien language.

Lambo's (1977) contribution was in treatment. In this regard, he developed the Aro therapeutic village approach which incorporated western and African concepts of healing. Lambo (1977) also initiated the process of dialogue between orthodox psychiatry and traditional healers, allowing each to learn from the other. Lambo and other African specialists were of the opinion that western psychiatry was not sufficiently individualized and communal to meet African cultural expectations (Okwu, 1979).

In conclusion, it can be said that although these specialists did not advocate the total abdication of western psychiatry, they did stress that its inherent cultural bias which was incongruent with the holistic approach to life of most third world cultures (Jackson, 1976). The argument was that western psychiatry embraced none of the basic tenets of African philosophy embodied by traditional medicine.

Diagnostic Categories

Introduction

This section will be devoted to the description of schizophrenia and personality disorders. These two diagnostic categories are presented because the study assumed that:

(1) most cultures recognize extreme forms of bizarre behavior which are usually contained in the schizophrenic adaptation; and

(2) personality disorders usually embody those forms of aberrant behavior contrary to cultural norms.

The overall objective in this section will be to describe these classifications, what they are and how they manifest themselves.

Schizophrenia

Overview

Schizophrenia, as a diagnostic category, has received much attention. It has been the subject of a great deal of debate regarding its origin (Mechanic, 1969). Despite this scholarly debate, schizophrenia as a diagnostic category was widely used, resulting in the classification of ten million people as schizophrenic in 1976 (Lehmann, 1976). The estimated annual growth rate is two million. Demographically speaking, this group has changed over the years with more leading a normal life despite the classification (Lehmann, 1976).

The controversy surrounding schizophrenia is formidable. For example, in reviewing the causal factors of schizophrenia, Cancro (1980) drew on surveys by Dalen (1974) and Odegard (1974) in Scandinavia where they found that a higher percentage of people labeled schizophrenic were born between January and April in the northern hemisphere. Dalen applied the same study to South Africa and found a higher proportion of schizophrenics born in the winter season. The conclusion arrived at by these investigators was that the fetus was exposed to a higher degree of stress in the winter season than in the summer. This was an extreme example illustrating the relentless debate surrounding schizophrenia.

This inquiry will not attempt to give a conclusive treatise on schizophrenia because it used schizophrenia in the broadest possible sense defined by Kohn as referring "to those severe functional disorders marked by disturbances in reality relationships and concept formation" (Kohn, 1979:129). Furthermore, schizophrenia, as the severest form of mental illness, is usually the type of disorder that western mental health services in the developing world are likely to treat.

Nevertheless, even though this research did not yet get involved in the overall controversy over the definition of schizophrenia, it recognized stress and genetic factors in causation (Cancro, 1980; Kohn, 1979). The genetic approach stressed constitutional factors as playing a major causative role, whereas the stress approach focuses on external factors found mainly in the environment (Cancro, 1980; Kohn, 1979; Mechanic, 1969). In this discussion much of the literature will be drawn from the studies undertaken by proponents of the stress concepts. The study was concerned with economic development a process affecting mainly the social and environmental factors. Consequently it had to draw from the psychological theoretical base that delineates the dynamic contribution of sociocultural factors to mental illness. This bias does not constitute a complete disregard of constitutional factors in mental health.

Symptoms of Schizophrenia

The presenting symptoms will be summarized below from the literature of Arieti (1974), Cameron (1963) and Lehmann (1980):

(1) Schizophrenia manifests itself through the individual's complete break with social reality.

(2) He/she adopts a language often incomprehensible to others, that is, language becomes impaired.

(3) There is complete disorganization and disorientation; the person has no sense of time regarding day or date.

(4) He/she may be withdrawn.

(5) Hallucinations and delusions are part of the overall behavioral manifestation.

It is important to recognize that these symptoms do not appear with regularity all over the world. For example, Leighton, et al (1963) found that regression in the African patient was less severe than in the Canadian patient, a finding which appeared with a great deal of frequency in the literature.

Lehmann (1980) described visual and tactile hallucinations (Arieti, 1974) as the distinguishing characteristics of African schizophrenics, who fall mainly into the hebephrenic classification. Lambo (1955) found differing symptoms between urban and rural schizophrenics in Nigeria. In a review of transcultural studies on schizophrenia Arieti (1974) reported that Ethiopian patients tended to be less dangerous than their European counterparts and presented symptomatology over-represented with magical preoccupation.

Schizophrenia is treatable and the earlier the detection the better the prognosis (Cameron, 1963).

Hebephrenia

The hebephrenic patient is one who laughs inappropriately, may mimic others excessively, is physically unkempt and, in short, presents peculiar mannerisms (Lehmann, 1980). Hypochondria and overall preoccupation with the body ensues (Arieti, 1974).

Epidemiological Studies on Schizophrenia

Schizophrenia has been the focus of many epidemiological surveys which describe the etiology and, more importantly, the incidence and prevalence of this disorder. In each of these assessments, specific environments were identified to further illustrate causative relationships between the disorder and socio-cultural settings. Settings such as inner-city dwellings (Faris and Dunham, 1939) and social class (Hollingshead and Redlich, 1958) were explored for their relationship to schizophrenia. Odegaard (1961) selected immigrant groups in Norway while Arieti (1959, 1974) chose to do a comparative cross-cultural study of urban life and its impact on mental illness in the United States and Italy. The Arieti (1974) inquiry came very close to being a transcultural epidemiological study. Murphy, et al (1963)

conducted a transcultural examination on schizophrenia with interesting results. These studies were mentioned to highlight the extent of interest in schizophrenia.

It was impossible to give a detailed description of these studies so just a few were identified. The criteria for selection was their relevance to this research as well as broad contribution to epidemiological research. In keeping with these criteria the following studies were selected:

(1) Mental Disorders in Urban Areas: An Ecological Study of Schizophrenia and Other Psychoses, Faris, Robert E.L., and Dunham, H. Warren (1939).

(2) Social Class and Mental Illness: A Community Study, Hollingshead, August B., and Redlich, Frederick C. (1958).

(3) Some socio-cultural aspects of manic-depressive psychosis and schizophrenia, Arieti, S. (1959, 1974).

(4) "A Cross-Cultural Survey of Schizophrenic Symptomatology", Murphy, H.B.M., Wittkower, E.D., Fried, J., and Ellenberger, H. (1963).

These studies will be described very briefly, with particular focus on findings and their applicability, or lack thereof, to this investigation.

The Faris and Dunham investigation was a classic piece of work which ushered in the era of epidemiological research. It was for a long time the ultimate reference on the causal relationship between mental illness and environmental factors (Arieti, 1974).

Faris and Dunham conducted the survey in the city of Chicago

by using psychiatric admission records to ascertain the incidence of mental illness in the city. For the purposes of the research the city was divided into five concentric circles identified as the inner loop, the transitional zone, the third zone, residential zone, and commuter zone. The distinguishing characteristics of these zones was that they represented varying degrees of neighborhood stability with the inner loop as the least established and the commuter zone as the most stable zone. The transitional zone was heterogeneous in its population composition because it was inhabited by different ethnic minorities. The inhabitants of these zones became more homogeneous as the circles moved outward toward the commuter zone.

The sample was drawn from a listing of first admissions at the Cook County Psychopathic Hospital for the year 1930-1931. The total human sample came to 7,069. Another sample totaling 28,763 was drawn from the state hospitals, while an additional sample of 6,101 was drawn from private hospitals.

The findings varied according to the sample, for example:

(1) The hospital and state hospital samples reflected a higher percentage of patients from the poorer areas.

(2) The rates of admissions to hospitals and state hospitals diminished as the circles moved toward the commuter zone.

(3) Within each zone the researchers found a heavier concentration of admissions in areas where social disintegration was most severe.

(4) The sample from the private hospitals showed scattered representation throughout the zones. However, most of the patients were drawn from the third zone which represented apartment living.

Faris and Dunham (1939) concluded that:

> The highest rates of first admissions to hospitals for schizophrenics were in the central city area where a large proportion of persons from the lowest socioeconomic status resided; rates diminished as one moved toward the higher status areas, away from the central city (Babigian, 1976: 865).

Associated with these high rates of schizophrenia were personality disorders such as prostitution, alcoholism and delinquency. Faris (1955) ascribed the presence of these conditions to what he termed social disorganization in low income classes.

Hollingshead and Redlich (1954) initiated their study because they were concerned about the lack of class considerations as a variable in social research. They ascribed this void to the American-professed ideals of equality in which everybody was considered equal. However, these researchers observed that Americans did differentiate along class lines in interacting with each other. This discrimination was particularly evident along racial lines, with a disproportionate number of minorities represented in the lower socio-economic income bracket. The researchers resolved to explore the question of class in relationship to mental illness. They postulated that the treatment offered to the lower socio-economic class was qualitatively different from that offered the upper-middle classes. They posed the following research questions:

(1) Is mental illness related to class in our society?

(2) Does a psychiatric patient's position in the status system affect how he is treated for his illness? (Hollingshead and Redlich, 1954: 10)

Urban New Haven was the identified site. That is, all those domiciled in New Haven from May 31st to December 1st, 1950 could become part of the human sample. Patients were described as those who were in treatment with a psychiatrist, psychologist or psychiatric social worker. It eliminated all those patients who were treated by anybody else. The residency requirement excluded those commuting patients receiving treatment in the New Haven area on a daily basis.

Patients were drawn from state hospitals, veterans hospitals, clinics, private hospitals and private practitioners in New Haven and other parts of New England. The contact with other parts of New England was to ensure coverage of those patients who, although residents of New Haven, were receiving treatment outside the city on either an inpatient or outpatient basis.

Direct interviews were not necessary. The essential ingredient in this study was access to case materials from therapists. Interviews were conducted with treating psychiatrists. Except for those in private practice, sociologists on the research team classified all patients in the study into five social classes numerically identified as I, II, III, IV and V. Those in private practice were classified by the psychiatric staff.

The non-patient sample was composed of 3,559 housing units. Heads of households were interviewed by the team and often trans-

lators had to be used when respondents did not speak English because some people were new immigrants.

Findings in this study were extensively described in the book by Hollingshead and Redlich (1958) and in an article by both researchers published in 1954. Of particular relevance to this study were the following findings:

(1) Highest rates of prevalence of schizophrenia were found in the lower socio-economic group or Class V.

(2) Most of those treated within these groups (IV and V) were referred by the legal system, that is, through the courts, schools and probation officers.

(3) The upper classes were referred through the medical profession.

(4) Ambulatory treatment was minimal among the lower socio-economic group, leading Hollingshead and Redlich to conclude that they broke treatment and maintained it mostly during the duration of hospitalization.

Discussion

Distinguishing characteristics of these two studies were that they are based in the United States and their applicability to third world conditions are minimal. What was important to note was that they brought to the surface the issue of poverty amongst the inner city dwellers and its detrimental impact on adaptations. It was important to note that the Hollingshead and Redlich study has been the subject of much criticism because it did not sufficiently explore racial discrimination as a contributing factor.

This was particularly important because both surveys found a disproportionate number of ethnic minorities within the lower socio-economic groupings.

In reviewing a number of epidemiological surveys, Kohn concluded that the consensus among researchers was "that schizophrenia occurs most frequently at the lowest social class levels or urban society" (Kohn, 1979:129). It was a finding reached by the Faris and Dunham as well as the Hollingshead and Redlich teams. Kohn (1979) presented a framework within which to interpret these and other similar findings. He approached them from a stress theory perspective by defining lower socio-economic living conditions as stressful.

Kohn (1979) was of the opinion that the conditions under which low income people live generate stress. For example, they did not have the material resources at their disposal to take advantage of community resources so that, in the final analysis, the institutions did not benefit lower income people. As a result of this approach, he rejected the notion that lower income people have a higher incidence of mental illness because they are genetically unable to manage stress. Rather he suggested that the cumulative impact of stress made them more vulnerable. This was a more acceptable approach for this study.

It was impossible to present all that has been published on schizophrenia and the relationship between mental illness and environmental factors. However, it should be stressed that the

genetic explanation for the high incidence of mental illness in lower income families is not acceptable to this research. The genetic theory was less acceptable because it focused almost exclusively on factors pertinent to the immediate family while the stress theory incorporated causal factors in the broader socio-cultural milieu.

Transcultural Epidemiological Surveys

Three transcultural epidemiological studies on the incidence of schizophrenia are presented in this section. These are the Arieti (1959, 1974), Murphy, et al (1963) and Erinosho (1977) studies. The Arieti survey was concerned with a cross-cultural comparative analysis of incidence between the United States and Italy, while the Murphy, et al (1963) investigation explored a relationship between culture and schizophrenia. The Erinosho (1977) research investigated a relationship between psychotherapeutic interventions and the rate of recidivism among discharged patients. This study was particularly important because it was conducted in Nigeria.

The Arieti Study (1959, 1974), undertook to examine the U.S. mental health records for first admissions to psychiatric hospitals for the year 1949. By using these records he hoped to compare the rate of schizophrenia between the United States and Italy. The Italian records were obtained by an Italian psychiatrist,

Bonfiglio, who used the annual average admission rates for the years 1947-1949.

A wide geographic area was covered in both countries. Northern and southern Italy were represented in the Italian study while almost all major metropolitan centers were represented in the American records. Patients' records were reviewed. Arieti analyzed the United States records while Bonfiglio classified the Italian findings. The overall assumption in this study was that different cultural exposure, through specific child rearing patterns and interpersonal interaction, had an impact on the incidence of schizophrenia and manic depression.

Generally speaking, the ratio of schizophrenia was higher in the U.S. than in Italy. However, within each country there were some regional differences. For example, in Italy the incidence of schizophrenia was much higher in Northern Italy than Southern Italy. The American findings bore out the Faris and Dunham (1939) and Hollingshead and Redlich (1954) studies by identifying a high incidence in larger metropolitan centers. The District of Columbia had the highest incidence of schizophrenia.

Explanation of Arieti Study. In explaining the research findings Arieti divided Italy into two distinct cultural regions. Northern Italy he defined as industrial, with a culture similar to the cultures of contemporary Western Europe where life revolves around the nuclear family. Southern Italy, he perceived as

culturally representative of pre-industrial Europe. The way of life in southern Italy was more relaxed and the focus was more on the extended family. The mother still performed the caretaking role and worked mainly in the home. In short, although southern Italy had industrial centers, these centers had not affected the traditional mode of life. Arieti applied the term "inner-directed" to the culture of southern Italy and "outerdirected" to that of northern Italy. He concluded that less schizophrenia was generated by an inner-directed than outer-directed culture.

In contrast to the studies reviewed above, the overall goal of the Murphy, et al (1963) study was to examine schizophrenic symptomatology and its overall relationship to culture. Toward this end the authors used a questionnaire of twenty-six symptoms which they sent to the participating psychiatrists. The psychiatrists were expected to give some description of the culture from which the patient came as well as the main schizophrenic groups regularly treated. The psychiatrists were chosen from the international psychiatric network which the researchers had built over the years.

The sample ultimately produced twenty-seven countries which are broken down in Table 6. The overall findings regarding schizophrenic grouping were as follows:

(1) Paranoid type was reported in urban populations.

(2) Hebephrenia was reported mostly among Japanese.

(3) Simplex type was reported among Asians.

TABLE 6

Murphy, et al Study, Country Sample Breakdown

Africa/ Middle East	Asia/ Pacific	North America/ Europe	Latin America
Kenya	Formosa (Taiwan)	United States	Brazil
South Africa	Japan	Canada	Colombia
Nigeria	Java	Bulgaria	Chile
Uganda	Hong Kong	Germany	Peru
Kuwait	Korea (South)	Czechoslovakia	Ecuador
	India	Norway	Babados
	Thailand	Turkey	Martinique

Source: Murphy, et al, 1963, pp. 238.

Visual and tactile hallucinations were frequently reported among Africans and Middle Eastern populations. Delusions of grandeur were frequent among rural groups while those of destruction were frequently reported among Christians. Christians also reported delusions around issues of religion.

Furthermore, in Africa, the catatonic type of schizophrenia was observed by psychiatrists working outside the hospital setting. It usually manifested itself in extreme forms of excitation.

In conclusion, it can be said that the recovery rate has been high in Africa despite the shortage of appropriate pharmacopoeia (Olatawura, 1979). Furthermore the international pharmaceutical competition for markets has resulted in the monopoly of some companies which, in turn, determined availability of drugs. Olatawura (1979) was of the opinion that most patients were aware of the few drugs that were available and that self-medication was the norm in Nigeria. Psychiatrists and doctors would be well advised to explore what the patient was taking before issuing a prescription. Erinosho's study complemented the observation made by Olatawura (1979) as he concentrated on the qualitative nature of treatment rather than on drug therapy.

Erinosho (1978) made a study on the effect of different treatment milleus on the rate of cure in Nigeria. He selected two therapeutic settings, a modern psychiatric clinic specializing in custodial care and the Aro village which focused on community-centered treatment. The objective was to examine post-treatment results of these patients that is, the rate of recidivism.

The sample was composed of 150 patients discharged from the Aro mental hospital and 57 discharged from the Aro village. The duration of stay upon first hospitalization ranged in both cases from under three months and over three months.

To prepare for the research, the types of therapies dispensed were studied. The outcome did not produce much difference between the therapeutic interventions, deployed in each setting. Both centers used group psychotherapy, the same array of pharmacopoeia as well as electric shock.

Despite similarities in treatment, the Aro Village did not have any of its patients readmitted more than twice. The mental hospital had eight of its patients readmitted three times, with some more than three times.

The significance of the survey for this study was that the patients were Nigerians, with most diagnosed as schizophrenic. Furthermore, the setting that attempted to incorporate indigenous concepts of healing had better results.

These studies have illustrated at different levels the extent of the schizophrenic manifestation. The high incidence in the United States surveys has often been explained by others as a consequence of the ease with which American psychiatrists use this diagnostic category (Lehmann, 1980). The transcultural explorations associated symptomatology with cultural orientation. Murphy, et al (1963) found that the core symptoms such as emotional withdrawal, hallucination and delusions were universally

applied as diagnostic aids. The consensus in the body of literature was that all societies recognized schizophrenia as an extreme form of mental illness. It was also clear that all epidemiological surveys used psychiatric admission information. A person was defined as a patient once he/she presented himself/herself for treatment at a psychiatric unit. The recorded materials are what became the focus of most studies. Very little direct contact was made with the human sample.

In general it can be said that the consensus in the body of literature seemed to suggest that the prognosis was much better for the African patient than for the European (Ihsan, 1982). Furthermore, Murphy (1982) noted that regression of the schizophrenic patient was less severe where there was a strong supportive network than where the patient was isolated. Closely related to the question of regression was the issue of chronicity in the schizophrenic patient. It can be stated that the more severe the regression the higher the chances for chronic illness. Murphy identified six factors which could either promote or prevent chronic illness. These were social rejection, rigidity of role ideals, assignment of responsibility, reality testing, sick role typing, acceptance of dependency and social networks. These factors are self explanatory to a large degree. For example the more tolerant a society is of mental illness the less the likelihood that schizophrenic patients would be banished to institutions.

The issue of role ideals is particularly relevant in this

study. Murphy (1982) identified a construct explaining the schizophrenic adaptation referred to as the theory of conflict of role ideals. This construct delineated a condition where two conflicting prescriptions were attached to the same role. Individuals fulfilling these roles were expected to conform to both sets of expectations even though conforming to each set of expectations raised feelings of conflict with the value system supporting parallel expectations within that role. The ultimate response often led to a schizophrenic breakdown when the idealized role expectations were rigidity defined and could be reconciled with new prescriptions under the same role (Murphy 1982). This situation can easily arise in developing countries where there are two acceptable forms of behavior which often do not complement each other because they reflect different cultural philosophies.

Personality Disorders

Introduction

The dispute that surrounded personality disorders at the turn of the century was one of its inclusion in the spectrum of psychiatric illnesses (Jackel, 1976). This argument continued into the early sixties demonstrated by articles presented in the American Psychologist by Szasz (1960, 1961) and Ausubel (1961). The former recommended that personality disorders be excluded from psychiatric

nomenclature, while the latter enunciated numerous reasons for their continued inclusion into the listings of psychiatric ailments.

At the center of this dispute was the definition of mental illness. Szasz (1961) was of the opinion that the term mental illness should be used exclusively in cases where ailments had an organic rather than psychogenic origin. He believed the disease concept should be reserved for observations demonstrated on a physical basis and therefore that psychological phenomena do not appropriately belong within a disease model (Mechanic 1969:18).

The rationale that Szasz (1960, 1961, 1970) offered for the above contention was that the physiological sciences on which medicine was based was more objective given its repertoire of tested and confirmed theories of causation. Treatment was more predictable, objective and, therefore, more uniform. Psychiatric assumptions, on the other hand, were for the most part unconfirmed. Treatment was more subjective and less predictable (Ausubel, 1961; Mechanic, 1969). The argument was offered not only for personality disorders but for mental illness as a whole. Szasz (1970) remained convinced that mental illness was a myth.

In assessing personality disorders Szasz (1961, 1970) concluded that they represented problems of moral aberrations and should be dealt with under ethical and religious matters--philosophy and religion. He was further convinced that the label "personality disorder" was very often used to control minority

groups. By defining undesirable groups as ill, psychiatry expedited continued discrimination and exploitation of a people by granting the society the label with which to rationalize discriminatory behavior.

Ausubel (1961), while agreeing with Szasz that there were some ethical issues involved in the behavior of people suffering from personality disorders, argued for their inclusion into psychiatry. He affirmed that personality impairment occurred as a result of these disorders and because of this impairment the client should be placed under psychiatric care. This debate was terminated by the official inclusion of these disorders under the psychiatric nomenclature, personality disorders, which replaces the original term, character disorders (Cameron, 1963; Jackel, 1976).

Personality Disorders Defined

Defining personality disorders is most confusing because the term embraces a vast array of behavorial patterns. Furthermore, definitions of personality disorders are predicated upon the theoretical thrust adopted. For example, the psychoanalytic approach dictates concern with ego functioning and a scrutiny of libidinal fixations as well as an appraisal of intrapsychic balance (Ausubel, 1952; Jacket, 1976). The social psychological approach considers the issues of social interaction by appraising the individual's role performance (Cavanaugh, et al 1981; Varley, 1976).

The study will take a descriptive approach in defining personality disorders on which there was consensus. These will be summarized as follows:

(1) Personality disorders represent non-conforming behavioral patterns (Ausubel, 1961; Cavanaugh, et al, 1981).

(2) These behavorial patterns are ego-syntonic and not ego-alien. That is, the behavior affords the individual very little anxiety. The anxiety he/she suffers is temporary and occurs only when reprimanded by others (Jacket, 1976; Cameron, 1963).

(3) There is a low frustration tolerance. Behavior can be self-destructive (Cameron, 1963; Wishnie, 1977).

Personality disorders will be perceived, in light of the above description, as behavior inconsistent with those culturally prescribed under specific roles.

Identified Personality Disorder

Identifying specific personality disorders for this inquiry was important because personality disorders are not homogeneous. They present themselves under a variety of syndromes. For the purpose of this study, juvenile delinquency was selected. The rationale for this selection was that, more than any other, this form of behavior highlights disharmony in role expectations and role performance.

Juvenile Delinquency

Juvenile delinquency represents behavioral patterns exhibited by an adolescent which are incongruent with family and social expectations. The youth's performance of his/her role as a child or student is in conflict with cultural norms or values. Gibbons (1976) was of the opinion that juvenile delinquency highlights the sociocultural gap between youth and adult. He ascribed the high incidence of juvenile delinquency in the United States to intergenerational communication breakdown--one that has come about as institutions have mushroomed and neutralized the social control exerted by the family on the youth. This approach to juvenile delinquency was of particular importance to this study.

Varley (1976) suggested that usually the breakdown occurs at the primary level of role performance, that is, within the family setting. For this inquiry, there is a further point to consider. Upon reviewing of the literature, the author concluded that in the developing world the breakdown could occur at the primary and secondary levels, with the latter level representing a breakdown in indigenous culture (Varley, 1976).

This suggestion evolved from the observation that forced modernization through the introduction of modern institutions displaced the family as the primary socializing agent. Conflicting demands are made on the youth by the traditional and modern sector through the family and school respectively, which may create problems in communication.

In presenting this diagnostic category it was not possible to find a comprehensive study in the Africa region.

Conclusion

This section of the study was devoted to the description of two diagnostic categories, schizophrenia and juvenile delinquency. The objective was to describe the nature of these diagnostic classifications using symptomatology to illustrate how a diagnosis is arrived at. Where possible, characteristics peculiar to African patients was presented.

C H A P T E R IV

POINT OF SYNTHESIS: A CONCEPTUAL FRAMEWORK

Introduction

This chapter brings together literature presented in Chapters II and III into a theoretical framework, forming the conceptual base of this study. The synthesis is intended to serve as an analytical tool for the discussion on the Nigerian case study presented in Chapter V. Furthermore, it will guide discussions and recommendations in the concluding chapter.

Overview

Integration of development and mental health theories will be designed upon the premise that development models described in Chapter II seldom appear in the abstract format presented. Characteristics of the models emerge from government planning manuals embodied in development plans such as the five year development plans prepared by most developing countries. Objectives and policy statements contained in these plans, if analyzed for the degree of association between stated objectives and development

models presented in Chapter II, usually give an accurate picture of the modern or combination of models a country chooses to adopt in pursuit of economic development.

From a mental health perspective, a further analysis of policy objectives will be made to test for cultural compatibility between stated objectives and indigenous culture. That is, how culturally relevant is the policy or, more specifically, does the development policy reflect some basic tenets of indigenous "world view"? This is an important factor for consideration in this research because the author approaches theoretical models presented in Chapters II and III as abstractions of economic, social and cultural realities representing a philosophical and cultural bias of their developers. In essence, they are what their creators perceive to be the ideal functional representation of social reality; to those who adopt them they represent the means to an idealized goal.

A salient point in this study will be the overall recognition that different societies develop out of unique sets of geographical, historical, cultural and economic circumstances and, while there may be certain general principles of development applicable to most societies, these tenets must accommodate the different circumstances in addressing questions of social change and development in a given culture. There are dangers in attempting to absorb and reproduce a duplicate development in a given country that evolved out of particular experiences of another nation, even when such a plan may have been effective in meeting the needs of

the country in which it originally emerged. In short, development plans should reflect the distinctive set of conditions that have been a part of each culture's evolutionary process in order to address the growing problems that may plague it.

Historical Epochs and Their Behavioral Co-ordinates

The examination of literature in the preceding chapters facilitated the classification of major events in the developing world into three historical eras: pre-colonial; colonial; and post-colonial. This was particularly true of sub-Saharan Africa, which was the focus of this investigation. Each of these epochs was distinguished by economic policies introduced to exact behavioral patterns considered expedient for economic progress. The overall focus in this discussion will be on the colonial and post-colonial eras because they best illustrate the relationship between economic need and behavior.

The consensus in the literature surveyed indicated that the colonial era represented a significant turn in the history of developing nations. It marked the deliberate intrusion of developing countries by western Europe. This incursion was motivated by the need to establish new trading posts as European countries were engaged in the post-industrial competition for new markets (Baran, 1979; Bolland, 1979; Frank, 1979; Griffin, 1979; Rodney, 1974). Western Europe was at that time developing new markets. The

expansion manifested itself in the same manner throughout the developing world. Trade centers were established to collect raw materials for repatriation to the metropolis. Griffin described this pattern for Asia and Africa, while Bolland described the nature of this penetration in the following words:

> Belize still suffers from a colonial heritage that focused almost exclusive attention on a port and its connections with the metropolitan markets, to the detriment of the hinterland (Bolland 1979: 6).

The economic institutional framework established was one that neglected rural development, an observation made by many in the Africa region. Of particular importance to this inquiry were behavorial changes that occurred concomitant to accomplishing stated economic goal.

> One common assumption holds that underdeveloped societies are mired in the incapacity to manipulate natural forces rationally in the service of economic ends (Goulet 1971: 187).

This implied that indigenous cultures were very often perceived as incapable of nurturing economic growth. This belief continues to manifest itself today by the continued introduction of alien developments models which emphasize economic growth at the expense of other values (Bulhan, 1979; Illich, 1979; Morris, 1979). The implications of this development strategy for human adjustment will be more fully explored in ensuing section.

Table 7 highlights the significant issues discussed in this section.

TABLE 7

Economic Policies and Their Behavioral Coordinates

Era	Economic Policy	Psychological Implication
Pre-Colonial or Feudal	Subsistence	Harmony between economic, social, religious, and political behavior because they were guided by the same cultural edicts.
Colonial	Export production. Restructuring of the institutions to channel raw materials to the metropolis.	Edification of western culture, resulting in conflict between traditional and western - concepts of behavior (Fanon, 1967). Alienation through the development of negative self concepts (Bilhan, 1979).
Post-Colonial or	Economic development for the purpose of local institutions.	Continued domination of western concepts in defining identity and self-affirmation (Abdullah, 1977; Bulhan, 1979).

From the above discussion and table, it is clear that domination of developing countries by western countries was not only limited to the economic sector but extended to the whole range of human behavior. To accomplish the economic objective it was essential to elicit the cooperation of the indigenous people. Incentives were awarded for the development of appropriate western behavior. With the advent of political independence it became increasingly imperative to develop appropriate behavior over a large segment of the community.

Inkeles and Smith (1974) indicated in their research that appropriate modern behavior was characterized by principles of achievement and technical competence rather than those of affiliation and experiential knowledge. The behavioral repertoire of modern individuals was marked by individualism and self-orientation while the more traditional orientation valued collective living and communal orientation. Although Inkeles and Smith (1974) concluded that modern behavioral traits were culture-free, these traits were disproportionately represented within the cultures of Western countries.

Leighton, et al (1963) in their research in Nigeria suggested that formal education was the primary institution for the promulgation of modern values. They further suggested that it could breed alienation, a factor found by Amer (1970) in the Africa region. Speaking on this issue for the developing world, Fanon (1967) indicated that the values of colonialism created much anxiety in

the colonized because there was a sharp dichotomy between the values of primary socialization within the family and those of the dominant economic structure. Education as the bridge between traditional and western cultures was slowly encroaching upon traditional family responsibilities, neutralizing the family's role. It was vital in preparing individuals to function in the dominant western-oriented economic sphere.

Fanon's observation is relevant today. If Inkeles and Smith's proposition of behavioral modernization is accepted, it means that developing countries will consciously attempt to develop these traits in their citizens. It ultimately means that for the African continent, the values of affiliation and universal holism have to be replaced by behavior regulated by a more fragmented perception of the universe. Behavior has to be compartmentalized for individuals to survive in a process of economic development. In short, it means that the erosion of traditional values commenced under colonialism would be perpetuated, as they are perceived to be the primary constraining factors to economic progress.

Nevertheless, a reading of the economic models in chapter II revealed that different models sought different levels of cultural diffusion by Western cultures in developing countries. For example, the Rostowian model sought wholesale imitation of Western countries by developing countries while the principle objective of the Institutional-Structural models was a blending of traditional and Western cultures. Inkeles and Smith (1974) would appear to

suggest the Rostowian model although they do not directly state it. Their recommendations and Rostow's basic outline of what constitute, economic development complement each other.

In conclusion, it can be stated that developing countries have the following options in formulating policies of development. They can adopt a policy that would encourage a synthesis of traditional values in overall development, or they can opt for one that creates a complete dichotomy between the values of tradition and modern living. The implications of these choices for mental health will be explored in the sections that follow.

Implications of Economic Development for Mental Health

Most developing countries have embraced the economic perspective in their development strategies (Bryant and White, 1982). The economic perspective described by Bryant and White (1982) was a way of putting forth the overriding concerns developing countries had with issues of economic growth. More specifically this perspective revealed the influence of Rostow's model of economic growth. This was true for Africa (Bryant and White, 1982: Young, 1982) and Latin America (Navarro, 1976). The basic characteristics of the Rostowian model described in chapter II can be briefly summarized as follows:

(1) The model encouraged the diffusion of Western values and technology to the Third World.

(2) It created a complete dichotomy between the individual's productive capacities and family life, creating a dualism between nature and person.

(3) It further separated Western cultures from traditional cultures and perceived the function of Western cultures as that of promoting growth in traditional settings. It perceived one universal method through which growth could occur.

From a philosophical perspective, using Anyanwu's (1981) analysis of Western and African perspectives, it could be stated that by fragmenting social reality the Rostowian model of economic growth embodied the Western cultural philosophy. According to this perspective there was a clear dualism between nature and person, and a further dichotomy between the physical and mental capacities of people. There was no consideration of the spiritual world, which was considered unscientific and non-objective. It was the world of objectivity that mattered, that World that can be quantified and measured. It was this objectivity that dominated the development sector, and one considered by Inkeles and Smith (1974) as pivotal to the process of economic development.

Because of its extensive basis on scientific validation, it can be expected that such an orientation will minimize the values of experiential knowledge. Consequently, it can be expected that the Rostowian development model would consider the basic African values of holism not only as irrelevant but as deterrants to successful economic development. The implications for mental health are inherent in this basic tension of Western and African values.

Each value system has specific role prescriptions embracing specific expectations. For example, under traditional African precepts it is important to obey elders because of the age differential whereas the Western values tends to afford respect to those who have achieved over the years. Stress could ensue from such conflicting demands made upon an individual. Conditions of economic development create these contradictions in areas where the value system is dramatically different from those incorporated within the official development strategy. The Inkeles and Smith (1974) study confirmed this point in their overall findings. They found fewer problems of adjustment in Israel than they did in Nigeria. They concluded that this was due to the fact that Israel had a longer history of modernization and more modernizing structures. The author would add that the value system required for modernization is not dramatically different from the indegineous Israeli culture.

As can be expected, mental health services under the Rostowian model a program of economic growth would favor a medical model described in Chapter III, which assumes a universality of symptoms and ignores cultural relativity. The overall emphasis would be treatment rather than prevention. The medical model and Rostowian model of economic growth complement each other by perceiving social reality in a fragmented fashion. This perspective can only create anxiety for those who perceive the world in a unitary, unfragmented fashion.

Despite the dominant influence of the economic perspective there are attempts by developing countries to consider basic human needs. A basic needs program would emanate from a social policy that emphasizes social equity. That is a policy that would perceive all groups in the community as having equal right to the satisfaction of basic needs.

Contrary to the Rostowian model of economic growth the "Basic Needs" program would concern itself more specifically with human adaptation. The "Basic Needs" program would be particularly concerned with incorporating indigenous religious values into the overall development process. The implication for mental health would be that an effort would be made at incorporating traditional concepts of mental health. Furthermore, because the African philosophy sees no dichotomy among the physical, spiritual and mental realms it is most likely that a "Basic Needs" program would incorporate mental health as an integral part of development, because of the concept of holism. Cultural relativity would be the norm, minimizing the basic contradictions embraced by the Rostowian model.

The "Basic Needs" approach is but one aspect of the Structural-Institutional school. This school of thought would clearly promote economic development guided by indigenous cultural precepts. The major objective would be to blend the two value systems, that is, the Western and traditional concepts of reality. This school is more likely to adopt a sociological model of mental

health that would be most concerned with the effects on mental health of cultural change inherent in development. Nevertheless, such a program would recognize the national income from which these needs are satisfied. A "Basic Needs" program would draw on culturally appropriate methods rather than prevent innovation because of an overridding concern with sophisticated tools of measurement. This does not mean that it would abandon reasonable measures of evaluation. What is implied is that the overriding concern with quantification contained in a Rostowian model often facilitates the displacement of such important considerations as mental health, which are perceived as depreciating the profit margin.

The predominance of this economic perspective and the resilience of the GNP as an indicator of development manifested itself through the uneven patterns of development perceived by people such as Navarro (1976) and members of the dependency model as well as the Institutional-Structuralists. The Rostowian model was distinguished by the concentration of benefits in the urban areas and the neglect of rural areas. This pattern left out a large segment of the population from the development process because most developing nations are agrarian in nature. The urban centers became the mecca of development because they housed the educational and health facilities and afforded other opportunities. Because of this, they became the central focus for the rural communities who were neglected. This condition created what Leighton et al (1963) called

a "reference culture" which they defined as: "Money, jobs, education, medical facilities" (Leighton et al, 1963: 188).

Reference culture was perceived in this study as a natural consequence of uneven development described above and in Chapters II and III. This orientation was a symptom of a culture attempting to adapt to new circumstances, be this mode of adaptation positive or negative to human development. It was a survival mechanism. Faced with a deteriorating rural environments and the elevation of a money economy, people sought the centers of development which presumably would offer some of the promised benefits of development. Approached in this manner, the reference culture was a potent tool in determining behavioral outcome.

In explaining the high incidence of schizophrenia in northern Italy and the United States as compared to southern Italy, Arieti (1959, 1974) resorted to Riesman's (1961) terms of "inner directed" and "outer directed" cultures. The former culture was defined as one in which family affiliation was very important. The maternal role was highly respected. The father was the breadwinner and the mother stayed home. The "outer directed" culture was one that emphasized material well-being. Mothers often worked out of the home to augment the family outcome. Arieti (1974) concluded that southern Italy demonstrated "inner directed" cultural characteristics which explained the low incidence of schizophrenia. Furthermore, in the United States, he found that the bigger the city the higher the incidence of schizophrenia.

The above explanation of the incidence of schizophrenia cannot be applied to developing countries. Forced modernization in the developing world houses a coexistence of "outer-directed" and "inner directed" cultural milieux. An outer-directed syndrome evolves in individuals when they attempt to develop outer-directed traits to survive in the modern sector which is based on the outer-directed value system. In short, the individual attempts to negotiate a livilihood in the modern sector by absorbing some of the modern traits. The economic sector within which most people have to function operates along the laws of scientific objectivity.

The central conflict that may occur in such a situation is due to the reality that the individual begins to function between these two different systems of expectations. The "outer-directed" culture described (Inkeles and Smith, 1974) upholds a system of role expectations in direct opposition to the "inner-directed" culture. Blending these two systems is crucial for adaptations. For example, successful Africans in the modern sense still have the responsibility of sharing their wealth with the extended family by educating relatives and maintaining older family members. This may come easily to some or not so easily, as is still the case for many others.

What evolves are two systems of expectations which are functional for either culture. The modern sector gives a message that elevates new forms of behavior as better than the parent culture, yet this system does not afford the individual the support structure that he/she needs.

If one accepts Anyanwu's (1981) premise that the African cultural philosophy is indelibly imprinted in the minds of even the most modern Africans, then one can expect that the coexistence of modern and/ African value systems would be stressful to most Africans. Applying Murphy's (1982) analysis of schizophrenic adaptation in traditional cultures, one could expect that this would be a particularly vulnerable point in the overall axis of African adaptation. Anyanwu's analysis would suggest that Africans generally never forget the traditional role definitions. These definitions which embody specific expectations may be in direct contradiction to the modern traits outlined by Inkeles and Smith (1974). The potential stress factor is extremely high. Consequently, it could be said that approaching the schizophrenic adaptation in Africa from a stress theory and conflict modern point of view might be more helpful to the client. This approach focuses most specifically on role conflict.

Janzen (1978) outlined the African experience with modernization very clearly when he stated that there was the world of the European and the world of the African. There was, according to him, no synthesis between the two, leaving the individual to move and manipulate the two to the best of his/her abilities. The Liberationists were most concerned with this issue because they maintained that the world of the European was always considered superior. Their objective was to create a synthesis but this resolution had to come from the people to ensure that it was indeed authentic.

The protagonists of the Liberation model affirmed that a development strategy that does not include traditional values created problems of self-esteem for indigenous peoples. Abdullah (1977) found this to be true in Nigeria. The Liberation model of development would be more specifically geared to enhancing self-esteem. It would be conducive to the maintenance of positive community mental health. Under such a model of development one might expect a more preventive approach to mental health, as described in the Sociological model in Chapter III.

Development as a Means of Self-Esteem

Another way of explaining the negative consequences of development for human adaptation is to examine its relationship to self-esteem.

Dignity and economic development are not incompatible. Most development specialists such as Apter (1977), Freire (1974), Gutierrez (1973) and Todare (1981) speak of development as a means of enhancing self esteem. A positive self image is difficult to achieve if definitions of self are contained in an alien culture. Concepts of self are not relegated to family and social sectors. The totality of selfconcept evolves from the total social structure, i.e., the economic factors are equally important in the total definition of self. It is for this reason that the author advocates a development strategy that is truly culture specific.

This implies that development should utilize indigenous culture for its political, social, economic and religious expression. Such a step allows for a harmonious blending of human behavior in formal and informal organizations. It does not require the withdrawal of a country from the international community, only the deliberate introduction of indigenous culture in the entire process of development.

The adoption of indigenous assumptions into the process of economic development often confounds some development specialists. The rationale for this being confounded may amplify Anyanwu's contention that Western intellectual assumptions are often perceived as the only accurate measures of reality. Indigenous cultures are perceived as controlled by experiential non-scientific rules which cannot accurately portray reality. This tends to sustain the dichotomization of traditional and non-traditional societies in the process of development. This dualism manifests itself in the splitting of reality into two domains: one for development, and one for indigenous life. The most forceful sphere is the one of development. It is around issues of development that nations rally and plan.

A good example of this dichotomy is offered by the Zairian policy of "Authenticity" which was aimed at the governing of Zairian life through traditional edicts. These codes guide behavior in the informal sector by defining dress, diet, and family laws. They do not determine behavior in the formal sector.

Participation in the development sector is predicated by the individual's schooling, fluency in French, and facility with the modern institutions. Furthermore, indigenous culture does not define dietary habits for all, as the elite enjoy the important foods of Belgium including imported water. Such abuse of indigenous culture is termed by Goulet (1971) as the instrumental use of culture because it is not comprehensive in approach but exploitative and expedient in nature. This is true in the Zairian case because the author observed that in Zaire, success is defined in terms of an individual's accumulation of money.

These contradictions have some implications for mental health. Wrzesinska (1980) observed that in Zaire, young women were particularly vulnerable to these inconsistencies in development policies. The family as the primary socializing agent was in no position to prepare children for functioning in the formal sector. Consequently, the educational system took over the socializing role. The educational system was not always successful because, for whatever reason, young women often did not stay in school long enough for this process to be successfully concluded. Such persons were unable to go into the growth sector, and, as observed by this author, often resorted to prostitution. Furthermore, successful completion of schooling was no guarantee for participation in the development process.

The essence of these disharmonies is embodied in the call for nationalism while maintaining alien modes of development. A

development strategy conducive to positive personality development can come about only if:

(1) negative consequences to human development are recognized;

(2) human considerations become the priority in development;

(3) development is perceived as the vehicle to self-actualization and

(4) leaders are willing to accept that development strategies can evolve from within their own cultures.

Relationship of Study Assumption to Literature

The literature reviewed in Chapters II and III seem to endorse the major assumption of the study which is that there is a dialectical relationship between personality development and total social reality including societal institutions. Institutions form part of the broader social structure within which individuals find themselves.

In reviewing literature of the Institutional-Structuralists, Dependency and Liberation models, it became extremely clear that their point of departure from the Rostowian model of development was on its over-emphasis of western cultural and economic presence in the developing world. The Institutional-Structuralists were of the opinion that such a presence of western culture tended to create needs which were inconsistent with cultural dictates, much more expensive, and depleted scarce resources. Basic needs, under

the Rostowian model, were ill-defined, and it made sense according to the InstitutionalStructuralists to incorporate cultural values to ensure that they determined national needs.

The dependency model advocates were of the opinion that developing countries would never eradicate the vast problems of underdevelopment unless international relations addressed the questions of equity. Self-esteem and human dignity, according to the Liberationalist, were irrevocably tied into the national and international systems of justice. In their opinion, a positive self image could evolve only if people were empowered with their own culture, that is, people in the developing world should be permitted to search for solutions by using their own intellect. That is a point supported by proponents of the three models, the Liberationists and Dependency model advocates and protagonists of the Institutional-Structural model. It is accurate to say that, at different levels, these analysts of development are concerned with human development. They constantly refer to the effects of development on human adaptation and, although they do not state these terms directly, they are implied in their work.

It cites in the writings of Fanon (1965, 1967, 1968), Bulhan (1979, 1980), Cabral (1973), Cesaire (1972), Freire (1974), Memmi (1965, 1971) and especially Nyerere (1974 that the psychological realm of development took shape. Emphasis is placed on Nyerere because his writings were more in tune with the contemporary era of development. Fanon's work is still the classic which many follow,

but his writings reflect an era during which colonialism was objectively crumbling. Fanon established most conclusively that colonialism was harmful to human development. As a psychiatrist, he used a group of already ill patients to illustrate the extent of this impact. Bulhan went along the same lines. He, like Fanon, used a group of people in the metropolis already experiencing problems of adjustment and illustrated the negative impact of a European mentality internalized by third world people. Bulhan (1979) however, connects this at a much broader level, implying that the economic problems of Africa, Latin America, and the Caribbean basis are largely due to this mentality. The hold that western culture has on the ruling elite is said to immobilize them, rendering them incapable of effectively eradicating those structures maintaining underdevelopment.

It was the studies presented under the sociological paradigm in Chapter III that brought this relationship even closer. Inkeles and Smith (1974) discussed the utility of modern behavior, a trait they considered value free and one brought about by exposure to modernizing structures. In reviewing their findings, they concluded that the reason that the Israeli sample presented them with more of these traits than the Pakistani sample was due to a larger presence of modernizing structures in Israel than Pakistan. The significant finding in the research for this study was that these modernizing structures did not just happen; they were, indeed, deliberately planned. Furthermore, the traits described under

modernity by Inkeles and Smith (1974) were contrary to those traits upheld in indigenous culture outlined in Chapter III. This does not imply that this study supported the association between indigenous cultures and stagnation. The overall argument made by this study was that the efficacy of indigenous cultures had not been sufficiently tested to truly evaluate its potential as a growth inducing tool The incursion of colonialism stopped its natural evolution creating problems in its own evolutionary process.

Summary

Discussions so far, have intimated on the mental health implications of the selected economic strategies embodied in the economic models described in Chapter II. This summary will delineate more specifically the mental health consequences of each model.

As indicated in Chapter I the basic assumptions held in this study was that the degree of compitability between western and indigenous cultures dictated the nature of mental health consequences. It can be expected that there will be very little maladjustment in a society where the value system is essentially the same as that found in western cultures. Literature reviewed in Chapter III would seem to suggest that the core of African culture is dramatically different to that of Western cultures. The implications for mental health become significant in studying

the strategies deployed under each model. The models have varying degrees of allegiance and reverance to Western culture, and it is this allegiance that becomes important in predicting mental health implications. Conflict is generated at the individual level where there is no attempt made to synthesize different cultures. The expectations in Africa is that the individual creat his/her own synthesis. Under the four models Rostow's model could be classified as a pure western model.

For example, when a country adopts the Rostowian Model for development, one can expect that the overall approach will be to adopt a western style of behavior. This behavioral style embodies modern behavior which according to Inkeles and Smith (1974) is the essence of development. These authors suggest that the objective of development should be behavioral change, toward modern behavior. These behaviorial traits subsumed under modern behavior are in contrast to African traditional behavior. Consequently, the consequences for mental health can be negative, because the individual is expected to pay allegiance to two contrasting value system. Abdullah (1977), Anyanwu (1981), Bulhan (1980, 1973) and Goulet (1971, 1974) have pointed out the difficulty of operating within two constrasting value systems. It can be expected that the tensions which ensue at the value level affect individual mental health negatively, and that Rostow's model would nurture such conflict.

The Structural-Institutional model would be more conducive to improved mental health because it attempts to integrate indigenous value concepts in overall development strategy. The individual conflict described above is lessened because of the value attached to indigenous culture and individual contributors. The Liberation model would enhance mental health even more because it creates an environment in which people are encouraged to feel proud of their heritage. Efforts are made to nurture individual self-esteem through the edification of indigenous culture. The Dependency model can be expected to have the same effect.

In conclusion it can be said that mental health can be greatly enhanced through the adoptation of the Structural-Institutional, Dependency and Liberation models of development, because of their focus on enhancing self-esteem through the integration of alien and indigenous value concepts in development. Rostow's model by negating indigenous cultures may have negative consequences for mental health by generating feelings of hopelessness and impotency.

Framework for case analysis.

The preceding discussions represented a point of synthesis in the body of literature presented in Chapter II and III. Extrapolated from this synthesis is a framework for the discussion of case material to be presented in chapter IV. The overall outline

will determine the substance of the case data presented. The questions raised under the overall headings are not new questions but are indeed related to the original research questions presented in chapter I. The following includes a brief description of areas that will be explored in the case analysis.

Historical Precedents to Economic and Mental Health Policy

Literature presented in the discussions of the Institutional-Structural, Dependency and Liberation models of economic development suggest that the colonial legacy continues to play an important part in the development of Third World countries. This legacy of development persists through existing institutions which have not changed. The mental health specialists discussed the legacy of dependent relationships which tied in with the dependency described in dependency theories. The objectives in this analysis will be to inquire into:

(1) Nigeria's development policy prior to independence.

(2) The value base from which the policy is formulated.

(3) The presence of an official mental health policy, prior to the study period, 1972-1977

Influence of Historical Factors Upon Current Issues of Social Policies

The overall discussion in this section will be to examine whether economic development and mental health policies adopted in the past interact with, or influence policies adopted today.

Economic Development Policy for Study Period (1972-1977)

The purpose will be to examine Nigeria's development policy today by identifying the economic model the country has adopted. In addition to this, the nation's actual mental health policy will be presented.

Philosophy Embraced in Policy Objective

The official statements of objectives will be analyzed for relevance to indigenous culture. In other words, these pronouncements will be examined to determine whether they reflect Nigerian culture. To do this, the literature on traditional healing will be used as a guide. The overall objective will be to analyze the relevance of these statements to African culture. Nigeria is a plural society which would require extensive anthropological material to present a precise synopsis of its culture. The question will be whether the African holistic approach to life and its values of affiliation in any way determine Nigerian economic policy.

Expected Outcomes of Policy Objectives

Once Nigeria's model of economic development has been identified, the issue will be whether the hypothesized outcomes under

such a model actually materialized. Administrative statistics will be presented to confirm or negate the outcome.

Unintended Outcomes of Policy Objectives

Once the actual outcomes of specific policy objectives are presented the focus will be on the unintended outcomes. Of particular interest will be the impact on mental health. This will be approached from a qualitative stance by focusing more on the impact on the quality of life.

Qualitative and Quantitative Changes in the Lives of Nigerians

This discussion will be an expansion of the two preceding sections. Material gains will be documented. At the qualitative level the question of mental health will be pursued from an African perspective.

Mental health statistics will be presented to highlight the qualitative changes. Ethnographic materials will be included to illustrate qualitative changes in value orientation.

Summary

This chapter has brought about a synthesis of Chapters II and III which will guide discussions in Chapter V. The salient point

in this chapter has been the observation that a comprehensive approach to development necessary for positive human adaptation can come about only if there emerges a composite coalition of thought which includes mental health perspectives This is particularly relevant for the Africa region whose overall philosophical belief system necessitates a holistic and cosmic approach to human life.

The framework for case analysis will be the guideline along which the policies of Nigeria will be explored for relevance to the African world view.

C H A P T E R V

NIGERIA: A CASE STUDY

Introduction

The preceding Chapters have focussed on an overview of selected economic and mental health theories which culminated in the development of a theoretical position in Chapter IV for the analysis of the Nigerian case study to be presented in this Chapter. Chapter IV outlined predictions that could be made of the conditions of mental health in a country, according to the economic model it adopted. The degree of cultural compatibility between the culture in question and western culture was considered pivitol in determining the impact on mental health.

Applying this evaluative tool to Nigeria certain predictions are made regarding its mental health conditions. Nigeria has adopted Rostow's model of economic development. It can be concluded that:

1) Individual adjustment is likely to suffer because of the value conflict that may ensue due to the differences in western and African cultures.

2) Nigerian culture is essentially African in nature, and the core of this value base is diametrically opposed to that embodied in Rostow's model. The

clash is due to the pull between individualism and communalism.

3) Contradictions between the developing sectors and indigenous sectors are accentuated by the dichotomy between urban and rural developments, which embody underdevelopment inducing mental anguish.

This chapter will therefore describe this development model adopted by Nigeria through an examination of social policies contained in the Second (1970-1974) and Third (1975-1980) Five-Year Development Plans. In analyzing the social policy statements, careful attention will be paid to assessing whether the predictable outcome of such policies on mental health are true for Nigeria. Although 1972-1977 was the identified period of study it was deemed important to approach this period in its historical context by briefly highlighting precedents to contemporary development planning in Nigeria.

The case study presentation will be conducted within the overall framework of analysis presented in Chapter IV. However, it is important to restate the original research questions presented in Chapter I which help delimit the specific data presented.

1. What is the philosophy, policy and mode of program implementation regarding mental health in Nigeria?

2. What do Nigerian scholars say about mental health in the context of economic development?

3. What is the philosophy and policy of economic development in Nigeria?

4. What do development specialists, including Nigerian development specialists, say about economic development?

5. What processes of change in value systems or belief orientation set in motion by economic development have an impact on mental health?

6. What should be the role of education in the integration of mental health in overall development?

7. What are the distribution patterns for Nigeria for the selected period of study? How was the GNP spent?

8. What are the implications of these spending patterns on mental health?

Consequently this chapter will be distinguished by the qualitative and quantitative analysis guiding the stated research questions.

Background Information

Nigeria is located along the coast of West Africa on the Gulf of Guinea. It is bounded on the east by Cameroon, on the North by Niger and on the west by Benin. It covers a massive land area of 923,768 kilometers of which 448.4 square Km are agricultural (Encyclopedia of the Third World, 1982).

Nigeria had an estimated population of 75,840,000 in 1980; it is estimated by the World Bank to be about 80 million today, with 85 percent of this population living in rural areas (Harrison, 1979). The population density has grown from 55.9 square km in 1960 to an estimated 71.6 square Km in 1970. The agricultural population density has grown from 125.0 square km in 1960 to 152.0 square km in 1970.

Method of Analysis

The research questions presented in this chapter, as well as in Chapter I, will be answered through a qualitative and quantitative analysis of the material presented. The qualitative and quantitative grouping of these questions remain the same as was the case in Chapter I.

Rationale for the Selection of Study Period (1972-1977)

It is important to note that the study period 1972-1977 was selected because it was an important period in Nigeria's economic, social and political development. It was a period marked by rapid socio-economic change. Nigerian analysts such as Herskovitz (1982), Kirk and Rimmer (1981), Rimmer (1981) and Williams (1976) agreed that the seventies were critical years in Nigerian history. It was a period of great opportunities, given the oil boom, as well as one of considerable social upheaval due to the Civil War (1966-1970). Questions of human and institutional reconstruction were raised by the Ibadan Conference (Ayida and Onitiri, 1971). These questions were raised at a time when Nigeria was experiencing its highest rate of economic growth (Diejamoah and Anusionwu, 1981; Herskovitz, 1982; Rimmer 1981). Diejamoah and Anusionwu captured succinctly this accelerated rate of economic growth in the following observation:

> The 1960-1970 decade on the whole did not witness a substantial gain in per capita income because of the disruptions in production as a result of the Nigerian Civil War in the 1967-1970 period. On the whole, per capita GDP increased at the rate of 0.6 percent per annum from 1960 to 1970. The Nigerian economy, however, expanded considerably in the 1970's with GDP growing at an annual rate of 6.2 percent (1970-1977). Overall GDP per capita increased at the rate of 3.6 percent per annum in the 1970-1977 period.
>
> The relatively rapid growth of the Nigerian economy has now pulled the country out of the ranks of the poorest developing countries and into the World Bank's category of middle income countries. The GDP per capita of Nigeria was estimated at 420 in 1977 by the World Bank (Diejamoah and Anusionwu, 1981: 90).

Consensus in the literature on Nigeria was that economic growth was due largely to oil revenues which quadrupled in 1973/4 as seen in Table 8. Increment in oil prices and increased extraction resulted in the establishment of the Nigerian economy as an oil-based economy, a point confirmed once Nigeria became an official member of the Organization of Petroleum Exporting Countries (OPEC) in 1971 (Rimmer, 1981). Such economic development helped propel Nigeria more quickly into the world economy and, according to some analysts, solidified its function as an oil supplier, in the international division of labor (Nnoli, 1981; Williams, 1976). The merits and demerits of such a development path for Nigeria and the implications for mental health and social spending will be more fully explored in the sections that follow.

TABLE 8

Production and Exports of Mineral Oil
1966 and 1969-77

Year	Output Million Barrels	Average Export Price (U.S. $) per Barrel	Value of Export Millions	Percent of Total Nigerian Export
1966	152.4	----	184.0	33.0
1969	197.2	2.17	262.0	41.6
1970	395.9	2.25	510.0	57.6
1971	568.9	3.05	953.0	73.6
1972	665.3	3.39	1,176.2	82.0
1973	750.4	4.80	1,893.5	83.1
1974	823.3	14.69	5,365.7	92.6
1975	651.3	12.95	4,563.1	92.6
1976	757.6	13.78	6,321.6	93.6
1977	765.7	14.56	7,072.8	91.9

Source: Rimmer, Douglas, 1981, pp. 50

Rationale for the Selection of Nigeria as a Case Study

Nigeria's abundant supply of natural and human resources accompanied by its prominence in international affairs has earned the nation the name "Giant of Africa". A review of the Second Development Plan indicated that Nigeria took this name seriously by dilineating as one of its major objectives the protection of African interest. The government deemed it necessary to adopt an aggressive economic policy that would sufficiently develop the economy so that Nigeria could in tern safeguard African interests internationally. These economic realities of Nigeria constituted some of the reasons Nigeria was selected for the case study.

From a mental health perspective, it is important to note that often mental health issues which fall under the overall umbrella of social issues are considered a luxury developing countries cannot afford. The period of study selected offered this researcher an opportunity of studying the direction of social policy in the midst of sudden economic prosperity--prosperity preceded by a period of serious social dislocation due to civil war. Civil wars are usually associated with periods of grave social upheaval for people. It is usually a stressful time associated with a great deal of material and personal loss. One would expect a period of war to be followed by some demonstrative efforts to rebuild the human infrastructure. For Nigeria, given its potential wealth, the expectation would be that such a program could at least be entertained.

The economic and mental health factors outlined above, accompanied by the fact that Nigerian social scientists have shown a great deal of concern with mental health issues, made for very compelling reasons for the selection of Nigeria.

Presentation of Case Material

Historical Precedents to Economic Development Policy

The data on historical precedents to contemporary Nigerian development policy would suggest that the first Colonial Development Plan favored the institutional-structural model while the first National Development Plan was most clearly a Rostowian model. The colonial plan was directly geared toward welfare distribution. Nevertheless, despite interest in welfare distribution, this plan was clearly not keen on incorporating traditional values in development. The objective was optimal production for the development of the metropolis. Welfare distributions came about only to assuage the colonized. The first national plan was more directly geared towards the development of the national economy. With the onset of independence in 1960 Nigeria was faced with the need to develop its institutions to ensure national financial security. The government chose what amounted to a Rostowian model of economic development as a means to economic prosperity.

It can be said that Nigeria's overall concern with economic development planning dates back to 1946 when the Ten Year Development Plan was introduced by Britain. It was a plan aimed at welfare distribution in the form of more educational opportunities and health services for people in the colonial possessions. Implementation of this plan, however, came about mainly through internal taxation felt primarily in the agricultural sector which was booming at the time due to favorable world market prices and increased demand (Herskovitz, 1982; Rimmer, 1981; Williams, 1976). During this period, the Nigerian economy was essentially an agrarian one, which explains the urban migration of that time (Home, 1976, Sada, 1981).

Marketing boards which were established for the purpose of taxing agricultural products became extremely powerful, and people such as Williams, a political scientist, are of the opinion that:

> The monopoly purchasing power of the marketing boards enabled the state to increase the rate of exploitation of peasant labour to finance emergence of a Nigerian capitalist class, and to finance the industrial investment, and the provision of urban services and amenities (Williams, 1976: 30).

This statement by Williams was partially supported by others such as Rimmer (1981) who maintained that the savings accumulated under this taxation system helped Nigeria implement its first National Development Plan (1962-1968). The question of exploitation was a serious one because Williams (1976) affirmed that board

members were often allowed to keep part of the money for themselves. The agreement was a tacit one between the colonialists and the regional chiefs.

Nevertheless, the first development plan introduced by Britain is one that was imposed on Nigeria and one which cost the country a great deal in agricultural revenue. Britain made some grants available for welfare purposes, but major spending under this plan was absorbed by Nigeria. Rimmer expressed financial accountability for the plan in the following words: "The average annual spending for Britain for 1955-1960 was 2.8 million whereas the Nigerian Government spent 38.4 million capital spending annually for the same period." (Rimmer, 1981:40).

This first ten year plan was formulated by the British government in conjunction with a central development board composed of senior government officials, most of whom were British (Rimmer, 1981; Second Development Plan, 1970). Nigerians made no direct contribution to its formulation but were expected to adhere to its principles of implementation by conforming to the taxation regulations imposed upon them by marketing boards (Rimmer, 1981). Britain, therefore, introduced the first step toward government regulation of the economy of Nigeria. It was no surprise that this plan met with a great deal of opposition from Nigerians. The people who paid taxes were getting more disgruntled at paying taxes without participating in policy formulation (Herskovitz, 1982).

The first development plan was followed by the first post-colonial development plan (1962-1968) which changed the focus most clearly from welfare considerations to economic growth (Rimmer, 1981). It should be noted that this plan covers part of the period known as the "United Nations First Development Decade" (1960-1970) during which the objective was to increase GDP by five percent through the repatriation of capital from developed to developing countries.

Nigerians were concerned with growing government spending incurred during 1946 to 1960 under the first plan (Rimmer 1981; Second Development Plan, 1970). To implement the objective of the first postcolonial development plan, the country opted to solicit foreign aid, a step in direct contrast to that undertaken in administering the first development plan (pre-independence) in which funds for implementation were internally generated through agricultural taxation. Welfare considerations were minimized because they were considered detrimental to economic progress. Education and health expenditures were retained because of political considerations. However, spending in these two sectors was to be kept at a minimum (Rimmer, 1981).

The plan met with considerable opposition, as at it appeared to reflect the needs of expatriates rather than those of Nigerians. Plan formulation followed very much the same pattern as that of the 1946 plan, it was highly centralized with little or no grassroots participation. Decision-making powers were vested

with government agencies whose major consideration was economic growth. In conclusion, it can be said that this phase of Nigeria's social history served to introduce the overall concept of economic planning and brought about a close relationship between the economy and government.

Historical Precedents to Mental Health Policy

A reading of the development plans and related literature showed no clear statement of policy for mental health. Nigeria conformed with Swift and Asuni's (1975) overview of African psychiatry which was, according to them, non-existent. The overall approach was a treatment which applied only to those individuals incapacitated by mental illness. Under these circumstances, the individual was then treated according to the treatment modalities of the metropolis. No effort was made to incorporate the methods of traditional healing. The overall treatment approach conformed with the Psychological model where the aim was to treat the identified patient away from the Social Milieu.

Influence of Historical Factors upon Current Issues of Social Policies

The preceding discussions have clearly shown that development policies were based on a western value system. During the

colonial era, which was the time period covering the First Development Plan, Nigerians were not consulted in the formulation social policy. The negation of indigenous culture was more direct. Welfare distributions were promoted in order to provide indigenous people with more educational opportunities with the result that they became more western in orientation. The first colonial plan surfaced when the winds of change were hitting the African continent and there was talk of independence. Africans were questioning the validity of continued subjugation to the British crown. Welfare distributions were undertaken to appease the colonies. The predominant feature still remained the economic growth of England, the metropolis.

There was a dramatic shift in policy with the formulation of the First National Plan. The major objective was economic growth, in keeping with Rostow's principles. The basic concern became one of modernization in order to increase production for the benefit of all Nigerians. Agricultural production was no longer the top priority. As a consequence, urban development appeared to become more important than rural development. This approach to economic development has persisted and was particularly visible in the language of the Second Five-Year Development Plan.

At a more qualitative level, literature on Nigerian development would suggest that the change from rural to urban development affected human adaptation most significantly. As a result of this conscious decision to modernize, Nigeria's development strategy

tended to reflect a Western orientation, which separated individual productivity from other areas of lives. Institutions increased rapidly while steadily absorbing some of the tasks of the community and extended family. The ultimate result was the compartmentalization of specific human functions into related institutions. For example religion was associated with church, learning with school, reproduction with the family unit and control with the legal system. To function in these institutions individuals required technical knowledge which meant the degree of readiness to function in the productive sector was always questionable because it was evaluated along different normative construct of eligibility.

This qualitative reorientation had some implication for mental health, because it meant that the individual was juggling two sets of behavioral codes. One was that of the original culture the other was that of the culture in which he/she must survive. The synthesis of these different value orientation is critical to mental health. A reading of studies such as Abdullah's (1977) and the critical writings of others seemed to point out this as the central point of conflict for most Nigerians in their adaptation of modernization.

Nigerian Economic Development Policy for Study Period (1972-1977)

A reading of the Second (1970-1974) and Third (1975-1980) Development Plans confirmed that Nigeria had for the study period

adopted Rostow's model of economic growth. The predominant feature was Nigeria's emphasis on economic growth as the primary objective. This objective was neutralized in the Third Development Plan by the language of equitable distribution reflecting the Institutional-Structural school of thought. Nonetheless, both plans were extremely clear that considerations for national equity should be deferred until the overall objective for growth has been met. The period under study was one of great economic strides marked by steady growth in the gross national product (GNP) shown in Table 9.

Affluence of the early seventies was preceded by a period of great social and political upheaval because of the civil war. As a result of the physical destruction caused by the war, the Second Development Plan shows a preoccupation with themes of economic reconstruction (Second Development Plan, 1970). Although the Third Development Plan built on this theme, it projected optimism born out of accumulating oil revenues which made the prospects for economic development possible. In addition to the theme of economic growth, the Second Development Plan expressed economic autonomy.

Autonomy was very important in the Plan and has its genesis in the First National Development Plan, the goal of which was to make Nigeria independent of foreign aid and technical assistance. The language of autonomy referred solely to Nigeria's relationship to the world economy. Nigeria was intent on developing its economy so as to ensure independence from the big powers. Toward

TABLE 9

Nigeria's Gross National Product Recordings for the Study Period (1972-1977)

Year	GNP
1970	120
1971	140
1972	130
1973	170
1974	290
1975	340
1976	380
1977	420
1978	560
1979	670

Source: World Bank Annual Reports [see bibliography].

this purpose, it accented the language of the dependency model which called for a new economic order.

Consequently Nigeria perceived as its primary goal the development of a strong economic base which would allow it to be economically independent of world powers. Such independence was closely tied in to Nigeria's need to use its resources for the betterment of Africa in international relations. Autonomy and control over its resources was perceived by Nigeria as extremely crucial if it were to fulfill its Pan-African leadership role. This aspiration toward leadership is described in the Plan as follows:

> In the context of modern power relations in the world and specially of the international threats facing African people, Nigeria cannot be truly strong and united without a prosperous economic base. Material power exerts a disproportionate influence on international morality. Nigeria will, therefore, pursue relentlessly the task of development to make the national economy strong, dynamic and responsive to the challenge of world competition (Second Development Plan, 1970: 32).

In order to attain these objectives, autonomy and economic growth, the country elected to concentrate on agricultural, industrial and manpower development. Statistical analysis of monetary distribution by sector tells a different story of priorities, as enumerated above. Analysts such as Bienen (1981, Home (1976), Nnoli (1981), Rimmer (1981) and Sada (1981) agree that due to limited investment in the agricultural sector reflected in Table 10 the shift toward urban development begun under the First National Development Plan was intensified. For example, the table indicates that much of the national income earned during the 1970-

1974 period was invested in the urban areas. A very small percentage of this money was invested in the rural areas. This pattern of investment has helped change Nigeria from a food-exporting to a food-importing country (Home 1976).

Central to Nigeria's strategy of economic growth was the overall national policy of indigenization. This policy was aimed at ensuring that foreign investors shared some of the profits made in Nigeria with Nigerians. Indigenization was taken more seriously by the Military Government following Gowon's administration. Gowon was considered too lenient on foreign investors because he granted foreign firms liberal investment terms (Biersteker, 1978). There are critical writings which would argue that Nigerians do not gain from these investments today.

The discussion in this section can be concluded by stating that the predominant feature of Nigeria's economic development policy was economic growth. Social equity was not found to be a predominant factor in Nigeria's strategy. The overall result of this need for economic growth manifested itself in the nation's need to introduce modern western technology by modernizing its economic infrastructure in the 1972-1974 period. Nevertheless, although Nigeria adhered to the classical mode of economic development as the predominant strategy, the country adopted a somewhat different posture in international economic relations. In international economic relations, Nigeria supported the call for the New International Economic Order (NIEO). This posture demons-

trated itself through the use of a language that called for equality in trade terms, indigenization of economic activities, and parity in world trade agreements.

Mental Health Policy for the Study Period

Nigeria's development plans showed no direct formulation of objectives regarding a policy position on mental health. The health chapters of the Second and Third Development Plans emphasized the overall concern with the eradication of communicable diseases such as malaria, tuberculosis and meningitis (Third Development Plan, 1975). The Third Development Plan outlined specific objectives for expansion of existing mental health facilities as well as the erection of new buildings. Chapters on Labour and Social Welfare, Resettlement and Rehabilitation focused on such social issues as aging, destitution and juvenile delinquency (Second Development Plan, 1970; Third Development Plan, 1975). Nowhere was there a specific analysis of mental health policy.

In the absence of specific mental health policy, the Second and Third Development Plans were examined mainly to explore their indirect relevance to mental health.

Unlike the Third, the Second Development Plan made no mention of mental health, nor the establishment of psychiatric facilities. In a chapter on "Resettlement and Rehabilitation," mention was made of the government having:

> mounted a massive relief programme designed to alleviate pain, distress, starvation, anxiety and death in the war affected areas. The programme took the form of supplies of food, clothing, shelter and medical care for the needy, dislocated and homeless (Second Development Plan, 1970: 85).

Toward that end, £70 million was allocated. The actual expenditure was relegated to buildings and very little to actual services. The Second Development Plan was concerned with building an infrastructure, be it in the economic or social sector. An important issue raised by the Second Development Plan was that of self-fulfillment. The government advocated the notion of development as a vehicle for the enhancement of positive personality development. However, it did not outline how this was to be achieved.

The Third Development Plan was much more specific and expansive in its language pertaining to psychiatric facilities. It did not have a clear statement of mental health policy but it did mention building psychiatric facilities. In building these facilities, the overall objective was one of improving the bed ratio and existing facilities. The chapter devoted to "Social Development and Sports" mentioned building centers for the disabled, destitute, orphaned children and aging. Preoccupation was with modernization of these facilities through the procurement of audio visuals for social welfare; however, treatment was not discussed.

There was no mention made in either plan of a consistent

policy that could be applied to exploring causative factors of mental illness and other social problems. It can be deduced from this discussion that at the federal level Nigeria adopted a curative system of mental health--one which was characterized by the building of new facilities with no exploration of why there was a need for such structures.

Mental Health Models of Nigeria

Nigeria's official model of mental health services conformed with the outline by Collombo (1971) in Chapter III for the African continent. The overall system of care was one of treatment. The traditional system of healing had been completely ignored. Consequently it would appear as though, in keeping with Ihsam's (1982) observations in Chapter III, the mental health system in Nigeria was one that functioned by the universal psychiatric norms. Harrison (1979) confirmed this more directly to Nigeria when he remarked that Nigerian officials tacitly recognized traditional healing but were reluctant to incorporate it in the official system of health because it did not have a scientific base.

The predictable model of care would be the psychological model described in Chapter III. This is the logical model because it ignores cultural relativity in diagnosis. The operation of a purely western model of care in the midst of a non-western culture presupposes denial of all cultural relativity (which the psycholo-

gical model does). Consequently it can be expected that the cultural nuances demonstrating themselves through patient symptomatology could be perceived as part of the problem, rather than as the unique manifestation of a patient responding and attempting to cope with his/her peculiar environment.

Nigeria's Economic Development and Mental Health Policies: A Point of Synthesis

A striking feature of Nigerian policy was the absence of all serious consideration of social equity. Social equity is defined in relationship to Gil's definition of the term "social equality" which he outlined as follows:

> The principle of social equality derives from a central value premise, according to which every individual and every social group are considered to be of equal intrinsic worth, and should, therefore, be entitled to equal civil, political, social, and economic rights, responsibilities, and treatment, as well as subject to equal constraints. (Gil, 1976:3).

In relationship to national policy, it means that national planning and implementation of plans should reflect overall consideration of all groups. Consequently, the government should call on all segments of the population to absorb economic constraints for longterm goals at equal levels. Rural and urban communities should share fairly in the benefits and pains of development.

Under Rostow's model of economic development it is clear that social equity is not the primary objective. The aim is to develop one particular sector so that it, in turn, generates development

in others (Henriot, 1979). Under such a development strategy, social equity is postponed until economic growth is attained. Consequently it was not surprising to find that the Nigerian model, which mirrors this model, concerned itself in building only the industrial sector. This model would emphasize urban development above rural development, and encourage the diffusion of western technology. The overriding concern with economic growth would mean a de-emphasis on social issues, particularly such issues as mental health.

Mental health implications of such a model would focus on issues of value orientation. One would expect a great deal of value conflict because much of Nigerian society is still very traditional. The cultural philosophy would in general conform to the African cultural orientation spelled out by Anyanwu (1981). The center of this philosophy was, according to Anyanwu, man's coexistence with the universe. Rostow's model embraces a completely fragmented version of this universe, which means that the family, religion and work become compartmentalized in different institutions marked by specific places of assembly. The difference between western and Nigerian orientations was dramatised by Chinua Achebe's model attached in Appendix A.

The fundamental question raised by a reading of this ethnographic material was, have Nigerians changed their cultural orientation sufficiently today to make this ethnographic material irrelevant? The answer to this question was essentially negative.

The reading of literature on traditional healing and such critical writings as those of Nigerian philosopher Anyanwu (1981) spoke to the continued persistence of a cosmic universe in Nigerian and African philosophy. Achebe might have dramatized Okonkwo, the hero's mental decomposition to illustrate value conflict, but this struggle continues today.

Therefore the mental health problems that can be expected in Nigeria would be those reflecting problems of value orientation. Furthermore, under a Rostowian model of development, this stress could be further magnified because of the compelling need to introduce new technology for economic prosperity. There are certain predictable outcomes under this system of growth: mainly that policy will favor urban groups instead of rural groups; and that in response to this imbalanced approach, people will move to the cities in search of employment. The rural to urban migration would have disruptive consequences for family life through its disruption.

The question answered in the following sections will be whether or not all these predictable outcomes under Rostow's model of economic growth are true for Nigeria. This section can be concluded by stating that an examination of the two development plans showed that the nation had adopted a classical mode of economic development (Young, 1982). By endorsing the trickle-down theory, the government had essentially endorsed Rostow's perspective on economic development. Once the primary objective became

one of economic growth, the federal government flirted with issues of distribution without actively pursuing a policy of resource allocation.

In conclusion, the Nigerian model of economic development can be summarized as one that:

(1) Emphasized capital accumulation.

(2) Deferred an equitable distribution in lieu of economic growth. The Second National Development Plan described this in the following words:

> Emphasis has been placed on growth as a precondition for the meaningful distribution of the fruits of development. The 'National Cake' must first be baked before it can be shared; and the bigger the cake, the more it can go round at each succeeding round of the sharing game (Second Development Plan, 1970: 33).

(3) Focused on industrialization and mechanization, by a concentration on heavy industry.

(4) Concentrated on urban development at the expense of rural development.

(5) Emphasized on foreign investment in the Nigerian growth sector.

Points 3-5 in the summary above will become more clearly outlined with the unfolding of the statistics on distribution patterns. This part of the case presentation has addressed itself to research questions 1 and 3.

Philosophy Embraced in Policy Objectives

This discussion is pivotal in the overall case presentation for it addresses itself to the question of cultural relevancy in

the Nigerian model of economic development. Because of the central nature of this discussion, much of the analysis will be undertaken drawing heavily on the critical writings of African development and mental health specialists such as Abdullah (1977), Binitie (1976), Madunagu (1982), Nnoli (1981) and Sada (1981). The distinguishing factor here is that all these scholars are Nigerian, meaning that although they may have addressed themselves to the problems of Africa in general they tended to focus on Nigeria.

This discussion should certainly begin with some consideration of Anyanwu's work which centers specifically on the issue of African philosophy in general. As a philosopher, Anyanwu simplified the problem of attempting to analyze the philosophical base of economic development in Africa. He was of the opinion that the predominant philosophical approach in modern Africa is western. He based his remarks on the observation that African culture was often subjected to the laws of natural sciences incorporated in western philosophy. Most westerners applied the scientific western theories to comprehend the African culture. Based on this observation he concluded that African cultures were not represented in the international culture which, according to him, was not pure but a composite of different regional cultures.

The question raised was, is it true that Nigerian development values reflect western rather than Nigerian culture? Nnoli (1981), a Nigerian political scientist, was of the opinion that the Nigerian model of economic development did not draw from indi-

genous culture. It was western in orientation. He was of the opinion that it was most inappropriate because it was "based on a notion of development that commits us to a wholesale imitation of others and therefore, to a wholesale repudiation of our state of being." (Nnoli, 1981: 2) In this observation he captured the essence of the Structural-Institutional school of thought as well as the Liberationists and Dependency theorists who argued that imitation of the western cultures has negative connotations on the development of a positive self-esteem. The implication of this statement for mental health was clarified by Murphy (1982) in his explanation of the conflict model regarding schizophrenia. Murphy found that where people are expected to adhere to two conflicting value systems, they often respons to these conflicting demands by adopting a schizophrenic condition. He found this to be particularly true where indigenous culture is more rigid. Nnoli, although not a mental health specialist, indicated clearly that by following a western model, the nation elevated western values which resulted in the reappraisal of individual potency. Abdullah (1977), in her research alluded to in Chapter III, established that the definition of self in terms of western values often led to the development of poor self-esteem.

The importance of economic development has resulted in the predominance of a western perspective in Nigeria manifested through the overriding concern with academic credentials. Abdullah (1977) indicated that the Western culture became the basis of self-

definition in Nigeria and Africa. Madunagu (1982) was of the opinion that Nigeria's incorporation into the world economy determined the modus operandi, which was a classical Rostowian model devoid of all consideration for Nigerian people.

The western orientation dominated the mental health system too. Mental health services were oriented toward treatment rather than prevention. Rappaport (1979) observed that the mental health clinics in Africa embraced none of the customs of traditional healing. He observed that the healing process, in a traditional setting, was both a social and spiritual experience. The patient shared food with the doctor and the community. In the hospital centers, the patient was reduced to share food only with fellow inmates. The doctors maintained the professional distance required under orthodox psychiatric care.

Nigerian psychiatrists have distinguished themselves by the constant reminder to officials that traditional healing has positive characteristics. Harrison (1979) found that Nigerian government officials were the ones most adverse to the integration of traditional healers in the health care system. These feelings of ambivalence are reinforced by expatriate mental health specialists who consider traditional healing dangerous for patients. The absence of traditional healing in official guidelines of mental health further highlights the exclusion of indigenous culture in the formulation of the Nigerian Social policy.

This absence of partial integration of indigenous cultural

values was particularly striking in Nigeria, because the country houses the most innovative African therapeutic program on the continent. The Aro Therapeutic Village was initiated in 1954 by Dr. Lambo, a Nigerian psychiatrist. It was started as a day-care center for mentally ill patients, but soon changed into a therapeutic village scheme. Under this scheme the patients attended the clinic during the day while living with members of the neighboring four villages involved in the therapeutic program. Patients were accompanied by relatives because the admission policy stated that:

> patients be accompanied by their relatives-mother, sister, brother, or aunt-who should be able to cook for them wash their clothes, take them to the hospital in the morning, and collect them in the afternoon.
> (Lambo, 1968:99)

The family, as well as villagers (Foster Parents), were invited to all hospital functions. All social functions included the patient, his/her family and members of the village directly involved in the therapy. This approach to therapy created what Janzen (1978) observed as the therapy managing group in African treatment. In the treatment of both physical and mental illness the identified patient is surrounded by a supportive network composed of family and traditional healers. The therapeutic encounter is always between the patient and a network of healers.

Lambo created this social network by involving the villagers and the traditional healers. The villages provided the natural social milieu for the patients, enabling them to maintain contact

with real life. This extensive collaborative network in the treatment of one individual was termed either Orthodox or Unorthodox collaboration. Orthodox collaboration referred to the contact with Public Health officials, Department of Social Welfare workers as well as contacts with Departments of Anthropology and Sociology at the University of Ibadan around the patients' treatment. Lambo termed this contact Orthodox because it described conventional contacts ordinarily expected when a patient was in treatment. However, contact with traditional healer was discouraged and it was the contacts with these healers that he defined Unorthodox. Contact with traditional healers proved profitable, as the overall findings proved.

Lambo and his team found that:

(1) By treating the patient in a village setting and permitting relatives to attend they minimized the stress of separation from family members.

(2) The florid symptomatology exhibited by some schizophrenic patients was more quickly stabilized in a village setting.

(3) The social milieu promoted a positive transference intreatment, and hereby facilitated recovery. The village setting represented the African World View.

(4) The use of traditional healers was a success particularly with neurotic patients.

It can be said that the Aro Therapeutic Village drew on local cultural strengths of close family ties as well as a strong community orientation to sustain the patients. From a financial perspective it can be stated that these strengths helped minimize the

cost. The Aro clinic with its western-trained public health officials assumed full responsibility for the public health needs of the inhabitants of the four villages involved. Lambo used a basic African concept of barter rather than a pure financial exchange which might have been beyond the means of the villagers.

Despite this dramatic example of the positive outcome of a mental health system that incorporates traditional healing, officials still shy away from integrating these principles on a large scale. Asuni (1973), in his argument for the integration of traditional healers in health care, points to the successful incorporation of the traditional healers in the health care system of the People's Republic of China.

In conclusion, it can be said that Western belief systems dominate the economic and mental health systems, and that these systems are retained by official social policy despite the reservations expressed by Nigerian scholars.

Intended Outcomes of Policy Objectives

The preceding discussions have established that Nigerians opted for a strategy of economic growth, reflecting Rostow's model of development as outlined in Chapter II. Under this program, the following factors could be expected:

(1) Economic growth marked by an increase in Gross National Product (GNP).

(2) Uneven development with particular focus on urban/industrial development.

(3) Dependence on western technology and expertise.

As expected, Nigeria made tremendous gains in its GNP, as illustrated in Table 9. A reading of these GNP recordings show growth for 1972 and 1973 to have been particularly high. The question raised was what did this increase mean to the individual lives of ordinary Nigerians? Did their circumstances change significantly?

A reading of the distribution tables and the examination of critical writings on Nigeria by such analysts as Bienen (1981), Home (1976), Nnoli (1981), Rimmer (1981) and Sada (1981) suggest marked uneven distribution of the national wealth. The consensus in this literature was that the Nigerian pattern of economic development favoured urban centers above agricultural areas where 85% of the population lived. Consequently, agricultural production declined due to the lack of incentives to farmers. The declining investment in agriculture is reflected in Table 11 which shows that agriculture has steadily lost its power as a viable employment sector. The central issue reflected in the table was the ability for any sector to reimburse the individual in monetary terms. This does not mean that subsistence farming has declined. The change illustrated by this table shows the demographic change in Nigeria. In 1946 Nigeria was a thriving agricultural economy; in 1977 it was a struggling industrializing nation.

Addressing the issue of rural and urban disparities reflected in Tables 10 and 11, Bienen presents his observations as follows:

TABLE 10

Sectoral Investment of Nigeria's National Income

Sector	Total Planned Investment (Million) N	Urban Investment (Million)	%	Rural Investment (Million)	%
Industry	172.2	155.4	91.2	16.8	9.8
Electricity	90.6	80.6	89.0	10.0	11.0
Water & Sewage	103.4	84.4	71.6	19.0	18.4
Town & Country	38.2	36.0	94.3	2.2	5.7
Education	277.8	196.8	70.9	81.0	29.1
Health	107.6	90.4	84.0	17.2	16.0
Social Welfare	24.0	22.0	91.7	3.0	8.3

Source: Soda, P.O. 1981, p. 277.

TABLE 11

Percentage Sectoral Distribution of Modern Sector Employment, 1965-1977
(Establishments represemted in this sample employed 10 or more persons)

Sector	1965	1970	1975	1977
Agriculture	10.4	9.2	7.0	4.0
Mining	7.0	7.2	6.0	1.2
Manufacturing	11.4	19.0	21.0	14.2
Construction	15.4	13.7	14.0	15.1
Electricity and Gas	2.4	2.6	2.0	3.3
Distribution	7.5	7.2	6.6	8.0
Transportation and Communication	9.4	6.5	6.1	4.7
Other Services	36.7	34.6	36.7	49.5

Sector: Diejomaoh and Anusionwu, 1981, p. 95

> The Second Plan (1970-1974) put over 80 percent of total investment in urban ahead. Nigerian federal government expenditures on agriculture went from a 1971 figure to 0.5 percent of current expenditures in 1971 to 1.4 percent in 1975. The federal government's capital expenditures on agriculture went from a 1971 figure of 4.8 percent to 6.0 percent in 1975. Obviously, the government was not trying very hard to alter the rural-urban trend (Bienen, 1981: 7).

In short, the Second Development Plan showed a strong preference for urban as opposed to rural development. Urbanization came in the form of massive industrialization. The Second Development Plan, like the first, was prepared mainly by administrators with no grassroots participation.

Although the Third Development Plan was considered to be a much broader plan, combining economic growth with equitable distribution, it still continued the rural and urban disparities of the Second Plan (Bienen 1981).

Unintended Consequences of Policy Objectives

Discussions in Chapter II indicated that a Rostowian model often created marked disparities among people and sectors. The rich get richer while the poor get poorer. The consequences of this model were termed "unintended" because it was assumed that the Nigerian government would indeed not willingly deprive groups of people of basic foods.

Having opted for the Rostowian model, the country was forced to make certain decisions regarding investments. The decisions

referred to in the preceding sections forced an agrarian people to become urban. The determining factor was that the urban areas became the centers for employment and as the economy changed to a money economy, the need for money to procure basic commodities became essential. In short, Government investment patterns presented in Tables 10 and reflect inequality between rural and urban areas, with the latter benefiting from economic development efforts at a disproportionately higher rate. The concentration of industry and social benefits in the urban center result in a pull to the city, while conditions of stagnation in the rural areas create forceful pressures for urbanization (Ayeni, 1981; Bienen, 1981; Sada, 1981).

Sada (1981) undertook a study aimed at exploring the dominant reasons for migrating to Lagos. Lagos has an estimated annual rate of growth of ten percent. It is one of the most rapidly growing urban centers in independent Africa. Sada and his associates found that the move to Lagos was motivated by more than a search for employment as Table 12 demonstrates.

The findings would seem to point out that rural to urban migration results from a combination of factors rather than one single factor. For example, parents appear to play a role in the individual's decision to migrate to the city. Sada found that parents encouraged their children to move to the cities hoping that the migrant's repatriated earnings would elevate the family's standard of living. Migration was often not a solution because many of the migrants had few opportunities

TABLE 12

Unemployment by Original Reason for Coming to Lagos in 1972

Reasons	No.	%
Economic Opportunities	803	54.26
To Look for Work	649	43.85
To Learn to Trade	141	9.53
Bad Village/Home Life	13	0.88
Amenities	224	15.14
To School	206	13.92
City Attraction	18	1.22
Family Relationship	84	5.68
To Meet Parents	50	3.38
Parental Advice	34	2.30
Other Reasons	99	6.69
Have Always Lived in Lagos	270	18.24
Total	1,480	100.0

Source: Sada, 1981, pp. 276.

of employment because of the high rate of illiteracy among them (Sada, 1981).

An important finding in the literature on urbanization in Nigeria further implies that there is a higher concentration of educational facilities in the urban areas, particularly post-secondary institutions--a condition confirmed in Table 12 which shows that 13.2 percent migrate to Lagos for reasons of education (Ayeni, 1981; Nduka, 1976). Ayeni further established in his analysis that Nigeria's economic activities were heavily concentrated in the eight urban centers of metropolitan Lagos, Kano, Kaduna, Ibadan, Sapele area, Zaria, Jos and Ewekoro. The pattern of urban development in these cities began in 1965 with these centers enjoying 74.7 percent of total industrial activity in Nigeria.

> By 1969, the percentage of such activity had risen to 90.1 percent, and Lagos alone increased its portion from 37.8 percent in the former year to 50 percent in the latter, Although industrial development is taking place in other centers, especially in the state capitals, the pattern of industrial concentration is not likely to change radically in the next few years because of the initial advantage of the firms set up in urban centers (Ayeni, 1981: 253).

The advantage that these centers had and continue to have was the economic infrastructure which was originally built and developed for the shipping of raw materials to Europe. Today, they have become the centers of development.

It is important to note that despite the oil boom and the unprecedented rates in economic growth (making Nigeria a "middle

income country") it still experiences much of the poverty and underdevelopment suffered by other developing countries. There are many Nigerians on whom the oil boom has made no significant impact in improving their immediate conditions.

There are many critics of Nigeria's chosen path to economic development such as Ayeni (1981), Nnoli (1981), Rimmer (1981), Sada (1981) and Williams (1976), to name a few. The consensus among these critics can be summarized as follows:

(1) Nigeria's pattern of economic development creates regional disparities and houses extreme conditions of poverty.

(2) Disparities are not exclusive to the regional level but are also reflected in the incomes of people. There are the very rich and the very poor (Morrison, 1981).

(3) The oil boom has increased these disparities rather than neutralized them (Diejomaoh and Anusionwu, 1981).

These unintended consequences are quantitative and qualitative in nature. The quantitative effects are felt in the buying power of Nigerians and the qualitative impact is experienced in what is perceived as the overriding principles dictating behavior.

Quantitative Changes as a Result of Policy Objectives

The immediate quantitative effect of economic growth was that the Nigerian government became very prominent in international as well as African affairs. African disputes often result in Nigeria

being consulted. This prominence, as a result of economic prosperity, further confirmed the dominance of the western economic perspective. Nigeria is respected because it represents wealth, not because it represents a society that aimed at integrating the holistic African principles in its development plan. The government had more buying power, but a large number of the people remained poor (Sada, 1981).

Nnoli (1981) coined the term "artifacts" in his criticism of Nigerian development. The quantitative gains just described are for Nnoli not development but what he called the accumulation of artifacts. Artifacts are objects which form part of the human physical environment. For example, roads, houses, industrial plants are all artifacts. Nnoli was of the opinion that Nigerian development was synonymous to a procurement list of "artifacts". He did not see this process as development. The procurement of such items was, according to him, nothing but an effort at becoming like the developed countries, or catching up to them. Nnoli distinguished between development and non-development as follows:

> Development is neither catching up with the advanced countries nor the procurement of artifacts. Under certain conditions the artifacts emanate from the development process and reflect it. But the artifacts are not development itself and in certain cases may have no relationship whatever with that process. They reflect development only when they are the end-product of the efforts of the population to apply their creative energy to transformation of the local physical, biological and socio-cultural environments. This is the situation in the advanced western and eastern countries. They cease to mirror development when they are provided by foreigners. In the latter case the local population is merely

> acquiring the products of the other's development. This has been the experience of Nigeria (Nnoli, 1981: 36).

Consequently, true development would consist of the dynamic involvement of Nigerian culture in producing solutions to problems of living. Nnoli's appraisal complements the observations made by members of the Institutional Structural School of thought, Dependency theorists and Liberationists. Literature suggests that the benefits of incorporating indigenous culture in the process of development far outweigh the projected disadvantages.

Mental Health Implications of Development Policy

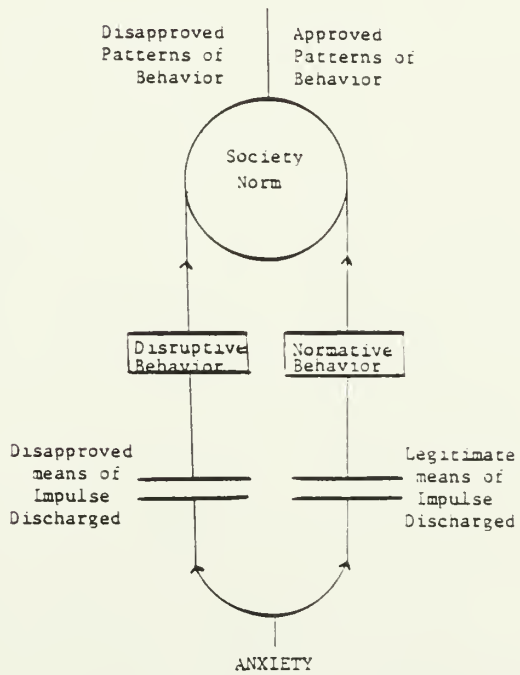
The preceding sections have alluded indirectly to the negative consequences of a Rostowian model of economic development for mental health. The ensuing section will concentrate more directly on the effect of Nigeria's policy on mental health. The overriding principle in this discussion is the assumption outlined in chapter I and confirmed by literature in Chapters II and III, that development affects people by focusing on institutions within which they must live and function. Furthermore, development is not value-free, but contains a set of knowledge evolving in a specific cultural milieu. As a result, it represents a culture from which this knowledge was developed (Goulet, 1971).

Along these lines, the point of reference in this discussion will be in the overall analysis of what implications two conflicting role prescriptions could have for an individual in a

setting such as Nigeria. Fanon (1967), discussed in Chapter IV, delineated the conflict that can occur in an individual who finds himself/herself confronted with expectations he/she is unable to fulfill. Furthermore, Fanon outlined the negative consequences of the predominance of a Western value orientation for Third World people who always find themselves at a disadvantage in this milieu because the primary socialization process does not complement later life realities. In Chapter IV, it was further indicated that a Rostowian model, which tends to elevate western values, can create problems of adjustment.

Binitie (1976), addressing himself to development in relationship to mental health, constructed a tool for measuring mental health in Africa (see Diagram 2). Binitie differentiated between the world of economic development, which operated by the values of scientific rationalism and that of traditions which functioned by experiential values. He then postulated that national goals which flow from scientific rationalism very often become incorporated in individual goals and manifest themselves in the individual persuits of economic prosperity and the search for formal knowledge. Normative behavior in the world of economic development reauires that the individual goes to school and obtains the necessary schooling to obtain a job.

Diagram No. 2: A model for the Measurement of Mental Health



Source: Binitie Ayo: 1976, p. 276.

However, Binitie (1976) made an important point, which was that in most developing countries the means to the national goal of economic prosperity are not accessible to most people. For example, education and jobs are hard to get. What happens in these particular cases is that individuals may resort to disruptive behavior such as juvenile delinquency or become mentally ill to cope with the anxieties of not being able to obtain their goals.

Abdullah (1977), in her research in Nigeria, explored this question at a different level. She was more specific about the question of mental illness as a result of value conflict. Her study analyzed how school girls defined themselves. She found that those Nigerian girls who defined themselves by western standards often had very low selfesteem. Abdullah and Binitie's work related most adequately to Murphy's (1982) observations of cultural conflict contributing to mental illness-schizophrenia.

Most of these specialists found in their analyses that economic development has implications for African mental health through changes in the socio-cultural environment. The mental health statistics that follow are a demonstration of the extreme manifestation that negative consequences occur as a result of economic development.

The analyses by African mental health specialists were conducted using African concepts of normality which relates to harmony with the universe. The suggestion is not that all Nigerians are mentally ill. What was implied in their evaluation was that living

in an industrializing society was stressful for those who operate by principles that value harmony with nature. Neither Abdullah nor Binitie found mental illness as defined by western nomenclature, but they found some conflict with the African value system.

Mental health statistics. Presentation of these statistics highlight the western approach to mental health which stresses case identification and isolation of the patient.

Government statistical annuals show a bias in the presentation of yearly statistics. Development statistics were reported fully, while mental health statistics were, at best, incomplete. Furthermore, mental health statistics were distinguished by the lack of consistency in format. That is, different diagnostic categories were used from one year to the next, resulting in a kaleidoscope of diagnostic classification over a period of time.

Irregularity was yet another feature of mental health reporting It was not unusual to have statistical annuals skip years of reporting mental health data. To illustrate these statements, mental health statistics on psychiatric morbidity are presented in two groupings below for outpatients and inpatients. The first set of statistics, under Tables 13 and 14 covers the years 1968-69 for Lagos State Mental Hospital and is taken from the Annual Report of the Federal Ministry of Health. The second set

TABLE 13

Outpatient Psychiatric Morbidity In Lagos
for Years 1965-1969

Lagos State Mental Hospital	1967	1968	1969
Total attendance	4,734	5,766	5,144
Average daily attendance	13	16	14

Source: Annual Report of the Federal Ministry of Health, 1974, pp. 54.

TABLE 14

Inpatient Psychiatric Morbidity In Lagos
for Years 1965-1969

Lagos State Mental Hospital	1967	1968	1969
Admissions	748	948	1,090
Discharges	682	1,203	1,002
Deaths	16	31	37

Source: Annual Report of the Federal Ministry of Health, 1974, pp. 54.

of statistics, presented in Tables 15 and 16, covers the study period (1972-1977) and was taken from a collection of government statistical reports from 1973-80.

The statistics shown in Table 13 reflect an increase in outpatient visits with slight decrease in 1969. The tables further indicate that while the numbers of outpatients decreased in 1969 after rising in 1968, inpatient admissions, increased, accompanied by few discharges and more deaths. The report made it clear that the profile of the Lagos Mental Hospital reflected that of the other three hospitals. Nigeria had in 1968 a total of four mental health hospitals with a bed capacity of 1007. More significant was the information that the bed capacity was reduced to 939 in 1969, although the reason was not given.

The statistics presented in Tables 15 and 16 reflect a central problem-inconsistency. Mental health statistics were not presented for 1972, 1975, and 1976, making it rather difficult to compare that annual rate. Other issues of significance were that:

(1) There was very little rigor applied to the presentation of mental health data. For example, 1973 was presented in undifferentiated form with no breakdown along diagnostic categories, while 1974 reflected classification along no sological lines.

(2) There was a higher incidence of outpatient care than inpatient care, which had to be limited to national bed capacity reflected in Table 17. The bed capacity tended to change from year to year even when the number of hospitals remained constant, as shown in table 17.

(3) If the number of mentally ill treated within the criminal justice system (Table 18) were added to the

TABLE 15

Inpatient Psychiatric Morbidity for Study for Years 1972-1977

Year		Inpatient			Outpatient		
	Diagnostic Classification	Male	Female	Both Sex	Male	Female	Both Sex
1972	Unavailable	2,618	2,620	5,238	47	18	65
1974	Psychosis	512	402	914	83	82	165
1977	Unavailable	1,450	1,166	2,616	13	10	23

Source: Annual Abstract of Statistics [see Bibliography].

TABLE 16

Outpatient Psychiatric Morbidity for Study Period 1972-1977

Year		Inpatient	Outpatient	
	Diagnostic Classification	Male	Female	Both Sex
1972	Unavailable	12,736	11,527	24,263
1974	Psychosis	6,250	5,388	11,628
1977	Unavailable	4,642	4,195	8,837

Source: Annual Abstract of Statistics [see bibliography].

TABLE 17

Profile of Mental Health Facilities in Nigeria for Study Period (1972-1977)

Year	Number of Hospitals	Number of Beds
1972	7	1,975
1973	7	1,975
1974	7	1,883
1975	Unknown	Unknown
1976	Unknown	Unknown
1977	Unknown	Unknown

Source: Annual Abstract of Statistics [see bibliography].

TABLE 18

Prosecuted Psychiatric Patients in Nigeria for Study Period (1972-1977)

Year	Offenses	
	Civil	Criminal
1972	76	44
1973	73	29
1974	105	44
1975	Unknown	Unknown
1976	Unknown	Unknown
1977	Unknonw	Unknown

Source: Annual Abstract of Statistics [see bibliography].

annual statistics, it would have increased the inpatient number for the study period.

(4) The incidence of "treated" mental illness was higher among men than among women, both on an inpatient and outpatient basis.

The cases recorded represented only those seen within the modern sector of psychiatric care. The patients seen by traditional healers do not appear in these statistics. If Rappaport (1977) and other observers of the African health scene are accurate, the recorded cases represent only those that were inaccessible to traditional treatment, i.e., those cases traditional healers are unable to treat.

Juvenile delinquency. Juvenile delinquency as a selected diagnostic category in this study was represented in Nigerian statistics in the criminal justice system. The assumption that can be made from such recording was that the list of delinquents appearing in these statistics are those that have been defined as nonconformist by the criminal justice system. This represents a larger question which is not within the purview of this study that is, does the criminal justice system represent Nigerian concepts of justice? However, for this study it can be noted that, according to these records, the rate of prosecuted delinquents rose dramatically at the time Nigeria was experiencing a peak in economic growth. Table 19 shows an increase in this rate.

Table 19 clearly indicates a steady increase in the number of

TABLE 19

Prosecuted Juveniles in Nigeria
for Study Period 1972-1977

Year	Under 16 years			16-20 Years		
	Males	Females	Both Sex	Males	Females	Both Sex
1971/1972	508	68	576	9,442	468	9,890
1972/1973	378	21	399	12,976	674	13,650
1973/1974	586	22	608	14,191	762	14,953
1974	---	--	252			14895
1975	---	--	704			16,931
1976	Unknown		3,933	Unknown		23,240
1977	Unknown		37,233	Unknown		23034

Source: Annual Abstract of Statistics, 1975 [see bibliography].

juvenile delinquents prosecuted. In both age groups, there were more boys prosecuted than girls between 1971-74. The sixteen to twenty age group appeared particularly vulnerable. The basic assumption made here was that the youth were arrested upon a legal violation. The statistics do not cover the delinquent outside the criminal justice system.

In conclusion, it can be said that the mental health statistics though incomplete, do paint a picture of increasing mental illness and related problems for Nigeria. The statistics do not reflect schizophrenia as a specific diagnostic category. The statistics do suggest some value conflict, given the tremendous increase in juvenile delinquency.

Summary

The overall findings in this chapter point to the absence of a clearly articulated mental health policy, despite existing research by Nigerian scholars that would seem to support the formulation of a clear policy. This would seem to confirm the findings in Chapter II which indicated that, the application of a Rostowian model tende to displace indigenous culture. Furthermore, in so far as mental health is concerned, it would appear that the overemphasis on technical competence in the Nigerian development strategy tends to create anxiety for the individual, who may often feel inadequate to meet the technical demands.

The implications of the Rostowian model described by Illich (1979), Goulet (1971) and others in Chapter II seems to have been borne out by the Nigerian Study. The overemphasize on western-style modernization has left many people on the margin of Nigerian development. The response is one that has created feelings of hopeless.

The mental health phenomena would seem to range from mild conditions of apathy to complete breakdown. The finding of African specialists was that this highly westernized model created problems of adjustment as self-affirmation was conducted along western norms, rather than African norms. This affected both urban and rural populations.

Mental health statistics presented in this chapter, though incomplete, seemed to indicate an increase particularly in the area of juvenile delinquency. It would appear as though the path of economic development chosen by Nigeria may have adverse effects on human development through rapid, unplanned change in the socio-cultural environment. Resolving these problems requires a successful reconciliation of the dichotomy created by the Rostowian model between indigenous and western cultures.

Despite the mental health conditions, the Government continues to promote a conventional treatment of health care-one that operated along the lines of the orthodox medical model. Statistics showed concern with ratios such as bed capacities and number of hospitals. In addition to this, government officials recognized

traditional medicine but were reluctant to incorporate it despite the urgings of Nigerian health specialists. The mental health system complemented the development strategy in that it relied heavily on Western techniques.

Nigerian scholars appeared to indicate that, in the midst of economic prosperity, there were extreme disparities between the rural and urban communities. The overall consensus in the literature confirmed that Nigerian development favored urban above rural development. This pattern created considerable migration to urban areas, which often did not meet expectations of the migrant.

C H A P T E R VI

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

The preceding chapters have discussed the relationship between mental health and economic development through an exploration of economic and mental health theories. General factors which affect mental health in relationship to economic development were identified, leading to the exploration of specific factors for the case study of Nigeria. From this analysis, some observations and findings were made which will guide concluding remarks as well as recommendations made in this Chapter.

Findings

Literature reviewed in Chapters II and III established that there was a dialectical relationship between economic development and mental health. More specifically there is an interplay between the process of economic development and human behavior. The incorporation of new knowledge through the process of development has a specific bearing on human behavior and ultimately on the mental health of those affected. This was the central issue that

concerned the protagonists of the Institutional-Structural school of thought, when they focused on human adaptation as the central issue of development. It was also a central factor in this study since it appeared as though some specialists such as those who supported Rostow's model of economic development encouraged the diffusion of western value systems in developing countries.

Further, this was a critical point for this study because the overall concern was with the mental health of people whose value orientation was markedly different from that of the developed world. African scholars seemed to agree that a development strategy that elevated western values above traditional values, without a proper synthesis of the two, had negative implications for mental health (Abdullah, 1977; Binitie, 1976). Critical writings by the World Health Organization affirmed this point (WHO, 1975; 1981). In light of these critical evaluations the findings for Nigeria can be summarized as follows:

(1) The country adopted, essentially, a Rostowian development model despite international and indigenous literature outlining the contradiction created by such a model.

(2) The overall objective was to create better living conditions for all Nigerians and economic growth was the perceived means to this goal.

(3) The emphasis on economic growth was particularly prevalent during the 1970-1974 period. For the latter part of the study period-1972-1977-the language reflected themes of distribution.

(4) Distribution patterns showed marked inequalities between the urban and rural areas with the urban areas sharing a higher percentage of the Gross National Product.

(5) Rapid economic growth was contained in the industrial sector resulting in a pattern of uneven development.

(6) Urbanization was on the increase.

These findings seem to confirm the discussions in the literature which suggested that economic development cannot be contained purely in institutions. The human element of development was the central filter through which economic development was ultimately implemented. The discussion raised the question of what happened to the filter when alien values were introduced.

Discussions

The study affirmed the principle of change which is inevitable in all societies while questioning the nature and speed of change. A discussion of the Nigerian case study findings will clarify this issue. As mentioned earlier, the national goal in Nigerian development was to improve the quality of life for all Nigerians. To attain this goal, the government adopted a highly westernized model of economic growth which emphasized modernization and industrialization.

Westernization was most striking in the area of health. Nigeria has so far failed to recognize traditional medicine officially because government officials were ambivalent about its advantages. Individuals such as Harrison (1979) found that government officials were uncomfortable about the official recognition of

traditional medicine because of what they stated to be the absence of a scientific base. This attitude persisted despite continued urgings by Nigerian mental health specialists that traditional medicine be incorporated into the overall health system.

The issue of traditional healing is particularly relevant because it embodies the essence of African cultures. A rejection of the system is tantamount to a rejection of basic indigenous culture. The central theme is that by accepting a scientific orientation over the more traditional one-without synthesis-authorities were indeed promoting technological advancement without tailoring these advancements to the African environment. The incorrect implication was that this new knowledge base was better than that contained in the parent culture. Ultimately the message transmitted to people was that the acquisition of this new knowledge was that the key to individual and national prosperity. This knowledge created a new and imposing social reality to which people had to adapt in order to survive. More specifically this knowledge base created a changed reality which had to be renegotiated. And this could only be done by referring back to indigenous cultural factors.

It was this cultural level of negotiation that had significance for this study. The rapid social change reflected in the Nigerian model of economic development had some serious implications for mental health by facilitating the erosion of traditional values through an objective focus on modernization. The

modern sector was clearly the more dominant one, representing western values. Parallel to this was the traditional system which represented the African culture and philosophy. It was in this regard that the Nigerian model could be said to contain contradictions which had negative consequences for human development.

The concept of indigenization was an economic rather than a cultural concept. It was aimed at ensuring minimal repatriation of profit made by foreign investors from Nigeria rather than at including indigenous concepts into the development process. No attempt was made to help integrate indigenous concepts in the development process. Furthermore, there are no institutional support structures in the modern sector that bridge the gap between communal societies and the western focus on the individual. The clash between these two different forms of orientation makes for mental health problems. By adopting a Rostowian model, Nigeria created a dichotomy between indigenous and modern values systems that cried out for synthesis.

The objective growth attained by this model of economic development contained serious inequalities reflected in Tables 10 and 11 and therefore hides considerable underdevelopment. Consequently, the underdevelopment of colonial times seems to have sustained itself mainly through the institutional framework. This observation would seem to bear out the writings of the Dependency theorists who argued that contemporary economic development was

not a process frozen in time. It was, according to them, a process rooted in the colonial relationship between colony and metropole. Literature revealed that this chronic condition of underdevelopment had serious consequences for mental health.

Specific Mental Health Outcomes of the Study

The condition of underdevelopment contains many of the stress inducing factors which contribute to unstable mental health. Underdevelopment, by housing extreme conditions of poverty, generated situations in which people seek wellbeing in the island of prosperity. These efforts at survival sustain social processes such as urbanization which in turn have consequences for family and communal solidarity.

(1) By an overemphasis on urban development the Rostowian model tends to promote a breakdown of the social support network.

(2) The literature reviewed in Chapter III revealed that an individual with diminished social networks, was particularily vulnerable to mental illness (Murphy, 1982).

(3) The promotion of technical competence makes it impossible for those without such skills to participate in the process of development.

(4) It can be said that for countries like Nigeria the push toward intensive industrialization makes it difficult for everybody to participate in building the economy.

(5) To attain the Social and technical competence with which to function in the developing sector, "resocialization" through formal and non-formal education becomes necessary.

(6) This process of "resocialization" puts the person in conflict between traditional values of cooperation and the competitive values of school and economic development.

In the light of the above, it can be said that by aspiring towards a Rostowian model of development economic, Nigeria has facilitated the erosion of the African values of affiliation because of the lack of integration between traditional and modern values in its modernization and industrialization process. The process of modernization described by Inkeles and Smith (1974) discussed in Chapter III requires the development of behavioral traits at variance with the African culture. Consequently, it can be said that the conflict experienced by most Nigerians has been the pull by the demands of contradictory value systems, an experience similar to that of Okonkwo the hero in Achebe's (1959) novel attached as Appendix A. Okonkwo's struggle was more pronounced because the traditional value system was not then neutralized, as it is now. However, modern studies of Nigeria such as the one conducted by Abdullah (1977) indicated that the clash between traditional and western value systems are still very significant for human adaptation.

The conflict arose from the dichotomization of traditional and western cultures as two opposing behavioral alternatives. The Nigerian strategy of development attached too much value to modernization, creating the illusion that modern behavioral patterns guaranteed access to full participation in the developing sector of society. Very often, advanced technical skills required in the

modern sector take more than the simple completion of schooling, a situation which explained the dependence on expatriates. Because of the rapid development in technology in the developed world, it was most unlikely that Nigeria would soon catch up with the developed, world where these technologies evolved. Most technological advances have a very short life span, becoming absolute with the formulation of new advances. It appeared to be in the best interest of Nigeria to find a way of blending traditional and modern values instead of creating this dichotomy. Blending the two value systems would lessen conflict with the values of affiliation and achievement.

Furthermore, it appeared that Nigerian growth was not equitably distributed. Most of the benefits remained in the urban areas where most services, such as health, education and recreational facilities were located. These facilities were inaccessible to the rural communities. Therefore, although Nigerian policy makers speak of increasing the size of the "pie" so that it can be shared, the institutional framework perpetuated inequality. Under the current arrangement, the rich get richer while the poor get poorer.

Recommendations

In keeping with the original outline, recommendations are presented at the national and continental levels. At the national

level, recommendations are for Nigeria and flow as follows:

(1) Development planners should be sensitized to the implications of a chosen path of economic development on human development.

(2) A more comprehensive approach to development should be taken in which rural and urban regions are deemed equally important.

(3) Mental health considerations should be incorporated into overall development because of the high rate of urbanization.

(4) Mental health considerations should be in keeping with traditional precepts defined by Nigerian social scientists and traditional healers.

(5) Mental health issues should be considered important in overall development.

The overall recommendation for incorporating mental health in development flows from the knowledge that there exist such human resources such as traditional healers, educators, community leaders and health personnel which have remained untapped. If organized, they form a vital source for mental health education.

The same recommendations hold true for the continent as a whole because the countries of Sub-Saharan Africa are more similar than dissimilar. In so far as mental health is concerned, some countries such as Botswana have already attempted to incorporate mental health into primary health care services. Nevertheless, the continent has done very little to incorporate mental health in overall development.

Detailed Framework for Mental Health Integration

Central to the inclusion of mental health in development was the question of policy formulation. The overall discussion in Chapters IV and V has been that the chronic conditions of underdevelopment in Nigeria and other African countries tend to be dehumanizing and, as such, detrimental to positive mental health or overall positive human development. The realities of underdevelopment and the social ills they contain are as real for Nigeria now as they were when it was experiencing its peak in economic growth in 1972-1973. It is important for social policy to reflect this reality. A policy statement sensitive to the cumulative effect of chronic poverty must by nature recognize human adaptation which would invariably mean sensitivity to mental health. Unless this approach is adopted, mental health workers in Nigeria and elsewhere on the continent will continue to find themselves engaged in the tedious process of "repairing the damage that societal conditions have created" (Mechanic, 1969:39).

Design Features

As alluded to above, Nigeria has human resources within the following institutions:

(1) Health

(2) Education

(3) Community structures

Health

The recent emphasis on public health services in all developing countries affords planners a splendid opportunity of utilizing nurses and nurses' aides in mental health education. In order to do this however, these specialists have to be trained in basic mental health.

Traditional healers should be incorporated as teachers or trainers because there is much they can teach the health staff. Communication between the staff and the healers should be one that is open and encouraged by administrators. Nigeria has much to work on even though it is ahead of many African countries because it has debated this issue openly.

Education

Education is a central institution because it is here that the hidden curriculum serves in changing the behavioral responses of students to meet the needs of a modernizing country. It is important that educators be made aware of the significance of education in overall adaptation. Chapters II and III highlighted studies on the African continent that confirmed education as a vital resocializing force. It is critical to ensure that the curricula blends in with indigenous culture to ensure a continued edification of traditional culture and vice versa. This requires the involvement of local people in defining the curricula.

The alliance between mental health and education cannot be sufficiently stressed. For example, in Tanzania which attempts to follow a more Liberationist model of development education is used in massive titeracy campaigns to help the individual get in touch with his/her African identity. To develop a strong sense of sense and pride in the African heritage appears the objective in Tanazia's educational program. This is one example that can be used in Nigeria's development. The point stressed here is the incorporation of African Communal Values in overall development and not GNP recondings. These suggestions have been made by people such as Abdullah (1977) and Erinosho (1979). Education can help in minimizing the dichotomy between African and western cultures highlighted in a period of economic development. Formal and non-formal education can be equally helpful because they should both strive to integrate important saspects of indigenous culture in their programs.

Community Structures

The community is an important source to draw upon. It is usually composed of indigenous people close to the source who have easy access to undocumented community history. They have a wealth of information, important not only from a mental health perspective but also from a planning point of view. However, if trained in mental health, they can be called upon to:

(1) identify community mental health needs;

(2) conduct educational programs;

(3) assist in the management of services; and

(4) decide on the nature and direction services should take.

In essence, they would provide grassroot participation which is now non-existent in Nigeria.

This is a very simple design for the beginning phase and can be built upon with the passage of time. No special institutions housing mental health services need be built. The institutions mentioned above are already in place in Nigeria.

In concluding this section, it must be stressed that these recommendations can only become viable if Nigerian planners actively include the numerous Nigerian psychiatrists in the country. The tendency in the interviews with Nigerian officials was to associate mental health issues solely with work at Aro Village. This is counterproductive to the excellent research papers coming out of this center because it is not integrated into overall policy. Nigeria has produced enough mental health specialists to be able to sustain any program on mental health provided that this program is preventive in nature and not just curative. A curative system calls for orthodox psychiatric personnel with little emphasis on prevention.

The mental health specialists in Nigeria are capable of providing the government with the necessary mental health consultation to ensure the smooth operation of the program.

Conclusion

It is hoped that this study marks a beginning of research in the area of economic development and mental health, especially in the Africa region where a great deal of development efforts are underway. Furthermore, it is clear that mental health issues focus most acutely on human adaptation, which is the presumed focus of development. Of greater significance are the findings in literature in Chapters II, III and V that there is a dynamic relationship between institutional development and the total social structure of a people, and that one affects the other.

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APPENDIX A

Enthographic Discussion

Introduction

The preceding section has clearly established the inadequacy of required statistics regarding mental health. To augment this gap Chinua Achebe's book entitled Things Fall Apart (1959) is presented. This novel termed a "developmental novel" by Goulet (1977) provides the researcher with an opportunity to present a description of mental health decomposition in light of rapid social change. To achieve this a precis of the book will be given followed by a critical discussion of its mental health implications.

Book Summary

The book described the emotional struggle of a man named "Okonkwo" in pre-colonial Nigeria. The struggle centered around his first contact with western culture through contact with the missionaries. Okonkwo was of the Ibo tribe and well respected by members of the clan--a respect which he had worked very hard to obtain. He developed his physical strengths and won two wrestling titles at a very early age. Okonkwo had three wives. As a member

of the "Eqwugwu" he had indeed achieved the ultimate point of self-actualization described by the culture. An "Eqwugwu" is a son, Nwoyo, joined the missionaries. Okonkwo beat the boy mercilessly and disowned him when he openly defied him and chose the missionaries. Missionaries represented the feminine traits which he found unacceptable. Okonkwo's suggestion to fellow clansmen was to fight them off the village property, but his maternal uncle and other elders suggested they be given the worst land in the village, concluding that the conditions on this land would eventually drive them away. Contrary to this expectation, the Missionaries stayed on, becoming more influential in the village life.

After the seven years of exile, Okonkwo returned to his native village only to find the missionary presence even more conspicious. In addition to the missionary, there was a commissioner who applied a new code of law alien to him and one in direct contrast to that of his village. Okonkwo was overcome with anger and confused by what he perceived as the village's complacency at the open display of disrespect toward indigenous religion shown by converts and missionaries alike. The ultimate form of desecration was performed by a convert who deliberately unveiled an "Engwugwu", challenging the community that no harm would come to him, for their god was not as strong as the god of the European. In retaliation, the elders burned a church, for which they were jailed.

In jail, they suffered indignities at the hands of the converts, who taunted them. Upon release, a village meeting was held and when the commissioner's assistant trespassed, Okonkwo killed him--and act that reflected the extent of his anger against the foreigners and their negations of that which was valuable in the Ibo culture. His consequent suicide came about when he realized that the village would not support him but would leave him to the devices of the commissioner.

Mental Health Implications of the Novel

Nigeria today is somewhat different from the Nigeria of Okonkwo. Today the country is quickly absorbing modern technology as a means to economic development. The aim is to modernize institutions as revealed in the Third Development Plan (Adedeji, 1980). The fundamental question is, have the people changed? That is, is their belief system dramatically different from that of Okonkwo, which attached tremendous value on affiliation, communal respect and constant contact with the spirit world. Have these values changed?

To answer this question it is important to note that Achebe dramatizes mental decomposition to project the basic value system of the hero. The central point of conflict in this story is the clash between a western value system, which prides itself with objectivity, and a traditional system, which prides itself with a sense of group identity. The Ibo culture had a set of rules which dominated the collective unconscious. It was clear and everybody

in the group could predict what was to ensue once the behavioral code was violated. It was this clarity in communication that helped Okonkwo determine that the accidental shooting of a clansman would be followed by seven years of banishment. He understood this and accepted it, with difficulty. The loss of a favorable position resulted in the onset of extreme depression.

It is important to note that the book illustrates that the precolonial time had its share of mental illness due to improper role performance and it was dealt with within the group. Okonkwo's uncle as the elder of the family calls the entire family unit to a conference and deals with Okonkwo's depression in a forthright fashion. He is supportive, yet firm. It is in this brief encounter that he reminds Okonkwo of his roles as a parent, son and husband, and the responsibility that underlie each role. Above all, he gently reminds him of the venerable nature of the maternal role because he knew Okonkwo's pain was due largely to having sought solace in his mother's village. He expresses his eloquently, as follows:

> "Listen to me, ' he said and cleared his throat. It's true that a child belongs to its father. But when a father beats his child, it seeks sympathy in its mother's hut. A man belongs to his fatherland when things are good and life is sweet. But when there is sorrow and bitterness he finds refuge in his motherland. Your mother is there to protect you. She is buried there. And that is why we say that mother is supreme. Is it right that you, Okonkwo, should bring to your mother a heavy face and refuse to be comforted? Be careful or you may displease the dead. Your duty is to comfort your wives and children and take them back to your fatherland after seven years. But if you allow

> sorrow to weight you down and kill you, they will all die in exile." (Achebe 1959:124).

Within this context the culture is able to give Okonkwo direction. However, when he is confronted with the missionaires, the cumulative stress becomes too much. By nature rigid, Okonkwo refuses all contact with the missionaires. Their continued assailment of his belief system becomes very difficult for him to bear as it is for others in the village. It hits at the core of his dignity as a man, something that was the center of his being. The Commissioner's negation of indigenous religion as inappropriate became unbearable to the point where he was involved in a direct confrontation with the alien culture. More painful to him was the diminishing role of his culture in daily living. His death occurs because he was trying to protect his culture from the indignities of Colonialism.

The author suggests that the traditional system of thought still exists in Nigeria. It is this belief system that precipitates the visits to traditional healers (Swift, 1972) and shrines. The developing sector has replaced the colonial governments (Morris, 1979). Even those Nigerians who have become emersed in the development sector resort to the traditional system in time of stress. The marked difference is that in Okonkwo's time, indigenous philosophies permeated the entire social structure; today, however, they are retained to interpersonal interaction in the informal sector, while the European dominates the modern sector.